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Nutrition

The Basis of Georgia's Nutrition Program

Nutrition Services in a County Health Program



The Hazardous-Occupations Program

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU



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• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Origin and Services of United States Committee for the Care of European Children¹

By ELSA CASTENDYCK,

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CONSIDERATION of the movement to the United States of children suffering the hardships of war can be divided into two parts, the first dealing with the interest and activities in the home country and the second concerned with plans and preparations in the United States. With the invasion of the Lowlands and the serious threat to France, interest centered on finding a way to evacuate children from continental Europe. However, the fall of France precluded that possibility. With Great Britain threatened by the spread of total war and possible invasion the plan to provide safety overseas for thousands of children was received with great enthusiasm in Great Britain. The original plan had had its beginning in the offers from British Dominions to care for children sent out from England. In June 1940 the Interdepartmental Committee on Evacuation Overseas was authorized by Parliament to draft plans and establish the necessary machinery for the evacuation of children to the Dominions. It was recognized that time was an important factor and that speed was imperative. The plan was drafted and early official approval obtained. The scheme thus developed was confined to children 6 to 15 years of age, not accompanied by a parent, and included arrangements for children of other nationalities living in Great Britain. Thousands of parents eagerly sought for their children the safety of

life overseas. It was reported that 200,000 children were registered for evacuation to the Dominions and to the United States. It was stated that parents of 32,000 children expressed their preference for the United States.

The scheme was barely under way when the dangers of the ocean voyage became apparent. In mid-July the British Government announced its decision to postpone its evacuation of children to the Dominions and to the United States, because warships could not be spared to convoy the boats carrying the children, and unprotected passage entailed a risk which the Government could not assume. Thus the movement which had been conceived as a mass evacuation was reduced immediately in size. However, the American Committee for the Evacuation of Children in London, an organization which had been formed under the sponsorship of the Ambassador from the United States and through the interest of United States businessmen living in England, proceeded with the plan to evacuate children to the United States. Subsequently, this organization received and registered the requests for evacuation of children to the United States; selected children for evacuation; facilitated shipping arrangements; provided such social information regarding the children and their families as was available; arranged for medical examinations; and obtained escorts for the voyage. In general it can be said it acted as the affiliate of the United States Committee for the Care of European

¹ Paper given at meeting of the Child Welfare League of America, National Conference of Social Work, Atlantic City, N. J., June 2, 1941.

Children in England. Shipping accommodations having been made available, the first children admitted under the plan arrived late in August.

What might be called part 2 of the refugee-child movement lies in the action taken in this country.

The appeal of a child in need is always arresting. It is little wonder, therefore, that the situation of children caught in the midst of battle, unable to express their needs or to defend themselves and facing overwhelming experiences, resulted in an upsurge of interest and sympathy which demanded immediate and efficient action. Thousands of persons in all parts of the country sought means of being of service to British children unknown to them. Many requested assistance in facilitating the arrival of children in whom they had a particular interest. The organization of the United States Committee, which came into existence in this period of stress and fear, was designed to provide some form of centralized authority through which such services could be rendered and which would assure an orderly plan guaranteeing the protection of the children in the future as well as at the present time. The demands for the evacuation of children presented an emergency situation which left little time for consideration of the essential legal and social safeguards, but there could be no uncertainty of status and circumstances if the children were to be established in their new homes with a minimum of hardships and heartaches. Desire to cooperate with the British Government's plans to evacuate children through the Children's Overseas Reception Board, thus strengthening Anglo-American ties which might affect the outcome of the war, was undoubtedly also in the minds of many of the persons interested.

The Committee faced the necessity of finding a solution for several major problems. In general they may be said to come under three headings. The first of these lay in finding a way of utilizing and converting into constructive action the interest and efforts of the many organizations wishing to provide care for European children, some of which were interested in special groups. Differing points of

view were readily overcome in the need for quick action. The organization of the Committee was effected at a meeting held in New York on June 20, 1940, under the leadership of Mrs. Roosevelt. The Board of Directors and the roster of sponsors represent various religious, national, and professional groups, thus affording means of coordinating group interests. The general purpose of the organization, as then stated, was to coordinate the available resources for the care of child victims of the war. The task before it was to provide care for children from the British Isles, as the fortunes of war had already made impossible the evacuation of children from continental countries.

The second major problem and one which presented unusual difficulties was that of providing means of speedy departure from England. The obstacles to this included the limited shipping facilities then available and the immigration regulations of this country. The methods of peace time, which required a visa granted by a consul abroad based on an individual guarantee of support, did not lend themselves to the pressure of a wartime emergency. The vigorous action of the Committee and interested individuals brought the problem to the attention of the proper governmental authorities, and on July 13 the United States Departments of Justice and State announced the adoption of a simplified procedure. This provided that alien children under 16 years of age, who seek to enter the United States to be safe from the dangers of war, would be admitted as visitors for a period of 2 years or on regular quota visas which permit an indefinite stay. Children admitted as visitors were not excluded on the ground that they were not accompanied by or coming to a parent in this country nor that their passage had been paid by a corporation or association or by a foreign government, regulations which had heretofore made impossible the entry of the children. Furthermore, the organization seeking admission for the children—

- (1) must be approved by the Attorney General for such purpose;
- (2) must give assurance that the child will not become a public charge;

- (3) must guarantee that the reception and subsequent care of the child will be in conformity with the standards of the Children's Bureau of the United States; and
- (4) must arrange that the sum of \$50, required by the Government to be set aside as a safeguard against certain future contingencies, be placed in a trust fund reserved for such purposes.

A fifth consideration of special interest to child-caring agencies provides that during their stay in the United States the children shall be under continuous supervision of welfare organizations if admitted as visitors; or if admitted on quota visas they shall be under supervision of welfare organizations until they are 18 years of age or for a longer period if required by the Attorney General.

As a basis for its corporate assurance on these points the United States Committee secured, for the most part through its affiliated local information committees, affidavits from individuals guaranteeing support of the children, or support and care in their own homes; and cash contributions. The affidavits assuring home care stated that the child would be cared for in accordance with the standards prescribed by the Children's Bureau, a provision intended to assure their health and happiness as well as safety in this country. These modifications in immigration procedures were effected almost simultaneously with the announcement that Britain's Government scheme for overseas evacuation of children had been temporarily suspended!

Social workers have long recognized that the transplanting of a child from home to home and community to community represents a major undertaking calling for skill and understanding. A British writer describing the evacuation of children in England says, "Evacuation is another name for dislocation." We know that dislocation lies at the roots of many of the social and behavior problems of childhood. It was readily recognized that a mass movement of children from a foreign country to the United States presented unusual difficulties in terms of both the welfare of the children themselves and the effect upon social services for American children. How could the guest children be assured care in accordance with their needs and interests? Could such care

be provided in the thousands of homes offered to these children or would such action open the way to wider and less discriminating use of free homes and jeopardize gains in foster care which had been achieved through the years with much effort? Was a large-scale plan for group care advisable? Would it provide greater security for the children by protecting them from or at least lessening some of the rigors which were involved in adjustment to a new country and new home? Could the child-caring agencies of the country absorb the extra load of supervising the care of several thousands of children from England without impairing the service which they were providing to American children?

These and many other questions were asked by social workers and other interested persons. Other refugee children had come to the United States. Small groups of children had been arriving from Germany and some of the Middle European countries and had been readily absorbed into American life. But there was no experience upon which one could base judgment in arranging for the care of thousands of children arriving in large groups. Perhaps, underlying some of these questions, although not openly expressed, there was some concern regarding the challenge which this offered to child-welfare agencies. Years of transplanting children has given social workers experience in the problems that are bound to arise. Here was a group in which blood ties, family custom, and tradition could not be expected to furnish either security for the children or guidance for the foster parents and agencies in explanation of behavior and attitudes. Some of the organizations accustomed to thoughtful and deliberate action in the removal of a child from one home and placement in another may have viewed with some misgiving their place in this venture on an uncharted sea.

There was not time to answer all these questions. The children were coming, and the new regulations which made possible their entry to the United States specified that the children would be cared for in accordance with standards prescribed by the Children's Bureau. The success of the project rested on three pegs—the United States Committee, which had assumed

the responsibility of bringing the children and guaranteeing their care and support, the agencies to which the Committee looked for assistance in the placement and supervision of the children, and the United States Children's Bureau, named by the Government to prescribe standards of care and to be assured that they were maintained. The formulation of statements of standards of care, procedures, and policies were developed in cooperation with the children's committee of the State Council of Public Assistance and Welfare Administrators; a committee of the American Academy of Pediatrics, and a special advisory group on medical care called together by the Children's Bureau, which included members of the Children's Bureau Advisory Committee on Pediatrics and representatives of the United States Committee for the Care of European Children; and the Advisory Committee to the Child Care Division of the United States Committee for the Care of European Children. The standards for the care of children adopted were based on the policies and practices that have been accepted and used by qualified agencies in providing care for children in the United States, particularly the standards for child-caring agencies and for medical care developed by the Child Welfare League of America. These included:²

1. General Standards for Child-Caring Agencies Designated for Service to European Children.
2. Standards of Family Home Care for Children (for use of foster parents).
3. Standards of Foster Care (for use of designated child-care agencies).
4. General Standards of Care of Children in Reception Centers.
5. Standards for Medical Care of Children.
6. Memorandum Concerning Group Care of Children (issued in tentative form).

It was unthinkable that these children who had experienced sudden and precipitate breaks in their normal life and relationships should have other than the best care offered by qualified child-caring agencies in the selection of foster homes and assistance in their adjustment to their new life. A total of 184 child-caring

agencies in 34 States were designated provisionally by the Children's Bureau in consultation with State welfare departments for immediate service in the placement and supervision of European children. By December 1940 the facilities of 221 agencies had been carefully reviewed by both the State agencies and the Children's Bureau, and 184 agencies in 40 States had received final designations.

The policies of the Children's Bureau and the United States Committee regarding family-home care and group care were based on the premise that these children, the guests of the people of the Nation, should be assured the kind of care which those in the United States concerned with the welfare of children are constantly seeking to make a reality. The variation in background, temperament, and special needs which characterizes children everywhere suggested the superiority of individual care in family homes. This plan offered greater possibilities than group care for participation in normal family and community relationships and activities and offered the means of preserving family ties, parental friendships, and acquaintances which a few of the children already had in the United States. On the other hand, some of the children had had group care in the home country, in some instances over long periods. Adaptation to new customs in an entirely new way of living appeared to offer certain handicaps. Consequently, both forms of care are in use; of the 870 children under the care of the United States Committee 801 are in foster homes and 69 are in group care.

The Committee, which for the purpose of evacuating British children to this country is the only organization recognized by the Governments of the United States and Great Britain, has assumed a serious responsibility of which it is entirely cognizant. The threefold obligations upon which its approval by the Department of Justice are based necessitate frequent contact with the agencies responsible for supervision of the children in order that the Committee may be informed regarding the whereabouts and general welfare of its charges. The periodic reports by the agencies to the Committee and its field service are designed to pro-

²These have subsequently been included in *Care of Children Coming to the United States for Safety Under the Attorney General's Order of July 13, 1940*, Bureau Publication No. 268. U. S. Children's Bureau, Washington, 1941.

vide assurance to the Committee and to the Children's Bureau that the prescribed standards of care are maintained.

Recognizing the need of providing a central source of information regarding all refugee children, whether coming to the United States under the auspices of the Committee or on the guarantee of independent sponsors, the Children's Bureau and the Committee collaborated in the establishment of a central register, which has been maintained at the office of the Committee in New York. For this purpose a "refugee" child has been defined as a child "16 years of age or under, who has been admitted to the United States since September 1, 1938, whose place of birth and/or last permanent residence is in a European country and who does not enter the United States to join a parent already in this country or is not accompanied by both parents."

Although all data since September 1938 are not yet available it appears that approximately 6,500 children have entered the United States since that date. Of these 3,439 were accompanied by a parent or relative and a total of approximately 2,400 were unaccompanied, including 1,584 who arrived independently of the United States Committee.

It is unnecessary to give detailed information regarding the arrival of the children. The expected overseas mass evacuation did not materialize. On October 3, 1940, it was announced that because of the dangers of ocean travel the British Government withdrew for the present its encouragement of the overseas evacuation. In deference to the wish of the British Government the American Committee in London concluded that it could not undertake further movement of groups of children. However, between August 21, 1940, when the first children arrived in New York, and October 3, when two ships carrying children arranged for by the United States Committee reached this country, 848 children arrived and became the responsibility of the United States Committee and the child-caring agencies cooperating with it. In addition several hundred children, admitted on consular affidavits, were given reception care and assisted in reaching their destination in the United States. In addition, 22 children have

subsequently come to the Committee from continental Europe. On May 1, 1941, the 870 children under the care of the Committee were being cared for in 21 States. Seventy-one designated agencies are cooperating now in their care, offering supervision and consultation to foster parents and sponsors. Generous assistance has been given by these agencies, by State welfare departments and State health officials, by Nation-wide organizations, and by scores of local agencies and educational institutions. In a program as far-flung as this, built under pressure and dealing with many unknown factors, variations in practice and response are perhaps inevitable. Schools, foster parents, agencies, and communities welcomed these children and were determined that they should be safe and well.

Since I have been closely associated with the work of the United States Committee from the time of its inception, I have been reminded many times of the values of this program over and above the benefits accruing to the children. In his report made following his return from England in October, Mr. Biddle, the former executive director of the Committee, says:

The British newspapers and magazines printed many letters from the children and photographs showing the reception and attention that the young evacuees were receiving in this country. America's wholehearted welcome has deeply touched parents, relatives, and the general public. It was for them a tangible evidence of friendship. It augurs well for the future relationships of the two countries and strengthens the most fundamental bonds that should more closely bind the two countries together in the reconstruction to follow the war, a factor realized by the British people even in these trying times.

There are, however, certain other values, real and potential, which should be given careful consideration. The placement of nearly a thousand foreign children in foster care, the experiences of the cooperating agencies, and the operation of the program on a Nation-wide basis are unique in the history of child welfare in the United States. Opportunities and challenges are offered on at least five points:

(1) The creation of a Nation-wide nonsectarian, child-caring agency having responsibilities and cooperating with 71 organizations in 21 States has never been duplicated in this country. It provides a means

for exchange of information and experience and for the examination of procedures and techniques which has heretofore not been available. It is to be hoped that the United States Committee and the organizations cooperating with it will recognize this challenging opportunity.

(2) The insistence that services to the children should be rendered by qualified child-caring agencies only has stimulated the examination of facilities within some communities and has created an awareness of lack of services or qualified staff. This was apparent in several communities in the efforts to provide organizations or strengthen the staffs of existing agencies to meet the qualifications. It would undoubtedly have been reflected to a greater degree had the program continued.

(3) The widespread interest in European children brought many persons in contact with social services (particularly child-welfare agencies) with which they had heretofore had no contact. New opportunities for interpretation of needs of children, whether they are European or American, have been discovered and are being developed.

(4) Many of the British children, unlike the children in this country for whom child-caring organizations assume special responsibility, have come from normal homes representing a normal cross-section of the family life of the nation whose citizens they are. They have been transplanted to an alien culture under trying conditions. Lack of information regarding the child's background, the relentless pull of conflicting loyalties, the cool, aloof reserve of children of another

culture and other traditions, the gnawing pain of homesickness are among the considerations ably discussed by Marion D. Gutman.¹ The reactions of these children to their new experiences should be of value to the entire field of child welfare.

Is there not also a lesson in the use of this new type of "free homes," a type of care which because of the exploitation and misuse of the past has fallen into almost complete disuse? A canvass of the financial resources as stated in the affidavits of would-be sponsors and foster parents shows a predominance of homes in the moderate-income group, rather than in the upper-income brackets, as was at first charged. These foster parents and sponsors frequently represent a group with which agencies have had little experience in the development of a client-agency relationship. This relationship unquestionably differs from that existing between the agency and the foster parent who receives some remuneration for services, but it nevertheless has many positive values. Agencies are being given an opportunity to demonstrate the application of principles and techniques in an area which up to the present has included only a minor part of the activity of most of the organizations.

(5) Finally, it should again be noted that "American people have experienced a lesson in organization for child protection not lacking in significance for their own defense program."²

¹ Marion D. Gutman: On Becoming a Foster Parent. *Survey Monthly*, Vol. 76, No. 10 (October 1940), pp. 286-287.

² Kathryn Close: When the Children Come. *Survey Monthly*, Vol. 76, No. 10 (October 1940), pp. 283-286.

BOOK NOTES

National Resources Planning Board Development of Resources and Stabilization of Employment in the United States has been issued in three parts by the National Resources Planning Board under date of January 1941.

Part 1, The Federal Program for National Development (Washington, 1941, 101 pp.), gives recommendations for a 6-year program.

Part 2, Regional Development Plans (Washington, 1941, 285 pp. Processed), reproduces statements prepared in the field in cooperation with regional and State planning agencies and with representative citizens.

Part 3 is entitled Functional Development Policies.

Child-welfare reports Publications in the field of social services for children have been received recently from several agencies. These include:

STANDARDS FOR CHILDREN'S ORGANIZATIONS PROVIDING FOSTER FAMILY CARE, revised edition, prepared by the Child Welfare League of America (New York, 1941, 57 pp., 35 cents).

This publication presents the basic principles of child care and the need for different types of services as well as the newer thinking and standards of service in foster-family care.

PARENTS WANTED, a pamphlet prepared by the Adoption Committee of the Family and Child Welfare

Division of the Buffalo Council of Social Agencies (Buffalo, 1941, 23 pp., 10 cents).

CARE OF DEPENDENT, NEGLECTED, AND DELINQUENT CHILDREN IN ERIE COUNTY, PA., a survey made under the direction of Helen Glenn Tyson at the request of County Commissioners, Juvenile Court, and Community Chest (Public Charities Association of Pennsylvania, 311 South Juniper Street, Philadelphia, 1940, 65 pp., 50 cents).

MANUAL OF HEALTH SUPERVISION IN CHILD CARE HOMES, second edition, 1941 (Catholic Charities of the Archdiocese of New York, 25 pp.). This is a report of the findings of a committee of physicians appointed to define practical minimum standards for health supervision in children's institutions in the Archdiocese of New York.

* * *

THE PARENTS' MANUAL—A GUIDE TO THE EMOTIONAL DEVELOPMENT OF YOUNG CHILDREN, by Anna W. M. Wolf. Simon & Schuster, New York, 1941. 332 pp. \$2.50.

Mrs. Wolf has written a book on the everyday problems that arise in families where there are children. Throughout the book Mrs. Wolf urges a "take it easy" attitude. Children can be fun, but it is easier for parents to enjoy them if the parents can but let themselves relax. Mrs. Wolf, however, does not confine herself to generalizations. One by one she takes up many of the questions and situations which parents find difficult. She gives practical advice on such matters as sleep and sleep routine, eating, bed wetting, stealing, and on many others.

There is a chapter on brothers and sisters—what they mean to each other and to their parents. Mrs. Wolf points out that no two children ever have exactly the same environment because, for one thing, the presence of more than one child in a family means that the parents treat one child as the eldest, one as the youngest, and so forth, and this treatment gives each child a slightly different relationship to his parents.

Sex education in childhood is discussed. Answers are suggested for the usual questions that a child raises, and advice is given regarding the child who never asks questions concerning sex.

One chapter is devoted to things to make and things to do both with and for children. Sharing of activity and sharing of joys are the most useful and the pleasantest parts of family life.

Problems of parents as grown-ups are stated to be at the root of many problems in their children's behavior. Parents need to look themselves over and try to settle their own problems before dealing with their children's difficulties. The author believes that a parent should hesitate no more about consulting a psychiatrist to get help in solving a problem than he would hesitate about calling a doctor to treat a fever.

D. V. W.

TREATMENT AND WHAT HAPPENED AFTERWARD, by William Healy and Augusta F. Brommer. Judge Baker Guidance Center, Boston, 1939. 54 pp.

The results of an evaluation of the later adjustments of 400 cases made after a lapse of 5 to 8 years following treatment at the Judge Baker Guidance Center are presented in this booklet. The group selected for analysis and follow-up study included all cases accepted by the clinic for treatment over a 3-year period—1931 through 1933—and included 280 boys and 120 girls. The median age at the time of referral was between 13 and 14. Approximately 85 percent of the children had intelligence quotients above 90 and none had quotients below 70.

The cases were classified according to the problems presented at referral into 3 main groups: personality or behavior problems, 207; noncourt delinquents, 137; delinquents referred from juvenile courts, 56. Of the total group 69 children were diagnosed as having abnormal personalities.

According to 8 criteria developed by the authors to designate favorable after-careers and 4 criteria to designate unfavorable adjustments, 91 percent of the children presenting personality or behavior problems, 70 percent of the noncourt delinquents, and 70 percent of the court delinquents were judged to have made favorable adjustments during the follow-up period.

Correlations of evaluations of after-careers with types and seriousness of delinquencies, with sex, with intelligence levels, and with the different types of abnormal personalities are also made by the authors. They note that 48 percent of the total number of failures are found among the individuals presenting abnormal personalities, who constituted only 17 percent of the entire group.

No detailed discussion of treatment data or procedures is attempted. Emphasis is placed upon the necessity of ministering to the varying needs of the individual, the cooperation of parents, the school, and others in close association with the child; but most important "are the intangibles that develop in the person-to-person relationship during the treatment process."

11. B. H.

• **BIRTH** •

• **GROWTH** •

• **CHILD HEALTH** •

The Basis of the Nutrition Program in Georgia's Department of Public Health¹

By EDWIN R. WATSON, M. D.

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In Georgia we have accepted as fact that those who worry about the condition of people in general are usually paddling the boat alone and that individuals with grave nutritional deficiencies or other health problems are frequently not concerned about themselves. In some way we must plan to elicit the interest of those for whom we are most concerned. It is not reasonable to believe that this interest can be immediately transformed into initiative. However, we believe that this must occur before a satisfactory program can materialize. It appears that almost any nutrition program must be conducted by optimists, because the changes that must occur before success is achieved can be visualized only by a farsighted person whose focus is in the very distant future. Certainly those of us in public-health work need the same point of view.

Adequate nutrition is contingent upon a complete change in our living standards, including social, moral, economic, and financial delineations. For example, many people do not differentiate between essential and nonessential items when spending their income, if they have an income. Others fail to purchase adequate diets and yet have money in the bank. Still others do not eat nutritious foods, and would not if they were served free, because no taste for these foods was ever developed.

Certain basic considerations required attention prior to the initiation of our nutrition program. In the past the approach to the nutrition problems has been made primarily by agricultural agencies, specifically the Extension Service. Other agencies have made contributions, but to my knowledge they have not formulated plans for the utilization of the information in such a way as to make it applicable to the public in general. It might be said without fear of contradiction that the Extension Service has been battling the problem without any concerted effort on the part of health agencies and has developed teaching methods that are adapted to the social, intellectual, and economic status of the people. Health departments could well afford to utilize the demonstration method of teaching which has characterized the work of the Extension Service. Most State extension agencies have at least one nutritionist on their staff. It is my experience that these extension nutritionists have gained information that is helpful to those inexperienced in the field of nutrition and public health.

Relationships With Other Agencies.

Realizing that a nutrition program conducted by a State health agency could not use the method employed by the Extension Service, we hastened to inform them that our proposed program would not in any way interfere with their efforts or objectives. We explained that our plans would not be in conflict with their

¹This paper is one of a series presented at the Conference of State Maternal and Child Health Directors with the Children's Bureau, Washington, March 24 to 26, 1941.

activities, and that our respective programs could work in harmony and supplement each other. This relationship was established with the Extension Service prior to the selection of a nutritionist. I might add at this time that the first visit made by our nutritionist following her arrival was to the Extension Service, where she had personal contact with the group. Largely because of previous preparation, the nutritionist was received with enthusiasm and was provided with information that had been reaped from vast experience and bitter disappointments.

When it was first determined that we would develop a nutrition program, all details were discussed with the president of the Medical Association of Georgia, who was thereby acquainted with the objectives. It has been our custom to clear both policies and plans that affect the practitioners of medicine with special committees from the medical association appointed for this purpose. This is done before any program is announced to our field personnel. In this way we have safeguarded against the reactions that are likely to result from misunderstanding and misinterpretation.

We were fortunate enough to have some funds from a national organization with which to initiate our nutrition program. We were immediately concerned with presenting the proposed plans to the national organization contributing the funds, so that their approval should be based on definite information and should forestall any criticism which might arise at a later date.

First Steps.

The foregoing points constitute our ground work. Our next step was to select a nutritionist. We corresponded with many and made a choice in August 1940. The selection of personnel is a difficult and yet a most important step. First, we were concerned about the background of the individual, because we recognize that habits, customs, and living standards in our State are in contrast with those of other areas of the United States. Since an individual who was experienced in field work and who had adequate training was not available, we chose to employ a person with a southern background

and a northern education. My impression is that this is an incomparable combination.

Immediately following the arrival of the nutritionist, arrangements were made to introduce her to the various public-health activities. It is our custom that each new professional employee have a personal conference with each staff member in the entire department in order to provide an understanding of the activities of each division as well as the activities of all staff members. This provided the nutritionist with the opportunity to determine with what services she should concern herself in the formulation of a nutrition program.

The next step was to familiarize the nutritionist with local health services, and this was accomplished through individual conferences with health commissioners and public-health nurses. In each instance their specific program was reviewed and problems were discussed, whether they were related to nutrition or not. In this way it was possible to acquaint the nutritionist with public-health problems in general, which is necessary if she is to have perspective.

In planning field visits the nutritionist arranged to visit the local health departments on the day when a maternal or child-health center was scheduled. Before the physician arrived the nutritionist had an opportunity to demonstrate food preparation to expectant mothers and to mothers of young children. This method provided the nutritionist with a means of evaluating her demonstration and determining how best to adapt her demonstrations to those particular groups and, in addition, gave her a definite insight into their present nutritional practices. As a consequence it has been possible to continue these demonstrations, this activity being assumed by the public-health nurse or by the home-demonstration agent. Repeated visits have been made by the nutritionist to these centers, to acquaint the public-health nurse with the details of this type of instruction. Our experience is that this is the most effective method of reaching this particular group. Since the meals thus prepared as demonstrations are served, it has been possible to convince parents that their children will partake of the foods advocated.

The nutritionist must be a person acceptable to all public-health personnel, and this acceptance must be based upon respect for her ability. For this reason, at our nurses' institutes, which are held once each year in four sections of the State, the nutritionist was given an opportunity to lecture to the entire nursing personnel. In this way it was possible to demonstrate that the nutritionist had information which the nurses did not possess but sorely needed. The nutritionist obtained an additional insight into the activities of public-health nurses through accompanying them on home visits, so that she might learn what was included in home visits, as well as the type of instruction relative to nutrition that the nurse was providing.

Acquaintance with other agencies engaged in nutrition work has consisted of the following: Conferences with the State advisory committee on State and professional projects of the Work Projects Administration, which is composed of the State director of the National Youth Administration, a member of the National Resources Planning Board, the State supervisor of Work Projects Administration lunchrooms, and others. Nutrition instructors and teachers of home economics in our colleges have been approached, and preliminary work initiated relative to a nutrition course for the elementary teachers, as well as a review of the curriculum for college students. Through conferences with the Extension Service it has been possible to point out how related problems can be attacked simultaneously and jointly. Through the State Home Economics Council, whose membership comprises practically every agency concerned with nutrition, including the Dietetics Association and the Home Economics Association, it has been possible to mobilize their efforts. Meetings with the various home-economics associations, as well as conferences with home-economics teachers, have provided an opportunity to review present plans and to outline future aims. Through contact with the Surplus Marketing Administration, the nutritionist has been able to extend in a cooperative manner the distribution of surplus supplies, both for school-luncheon programs and for the indigent who have thus far been denied this assistance. School-lunchroom managers have been visited,

suggestions for menu planning have been provided, means of securing equipment have been outlined, school gardens have been promoted, sanitation of the lunchrooms has been improved, summer gardens have been planned, and arrangements have been made for the preservation of food produced, for use during the following school session. Through personal contact with parent-teacher associations, interest in the school-lunchroom program has been materially increased, and results are already apparent. The Women's Medical Auxiliary has been supplied with material and aid in planning its nutrition program.

Other activities have included work with the Work Projects Administration nursery schools, Work Projects Administration adult-education teachers, radio programs, articles for our monthly publication (which have been reprinted each month by popular request, for distribution); a nutrition syllabus, into which essential information has been incorporated, which has been prepared for use by professional personnel; nutrition charts and posters that have been made available for exhibit purposes for Work Projects Administration and National Youth Administration projects; preparation of literature for distribution in maternal and child-health centers; and articles on nutrition published by official and nonofficial agencies.

Nutrition Council.

As was previously stated, a single nutritionist is unable to handle the problem satisfactorily, because the obstacles enumerated above will require the efforts of practically all agencies. With this in mind, we have planned to utilize the assets, abilities, and initiative of almost every type of organization. To this end a State-wide nutrition council was organized last fall as an outgrowth of the national-defense program. It is composed of representatives from 31 State-wide agencies and was planned by the Extension Service. This seemed an excellent means for launching a State-wide program based on objectives and plans that are expected to reach all social and economic strata and permit the application of those principles designed to meet specific problems. Thus far we have had two meetings. To my knowledge,

no organization that was invited has failed to send a delegate.

At the first meeting of the Nutrition Council the program was concerned with familiarizing the members with some of the problems and thus stimulating an active interest in the program. At this first meeting the committees were announced, their membership having been carefully chosen by the steering committee. Problems were assigned, and members were asked to formulate plans of action. This meeting was held in November 1940. Two months later the second meeting of the Council was held and each proposal by the committee was reviewed and adopted or modified. It is planned that the Nutrition Council will meet once each quarter so that progress reports can be submitted and future courses of action charted.

A brief description of objectives developed by each committee will best illustrate the methods of attacking problems related to nutrition, either directly or indirectly.

Committees of the Council.

The responsibility of the steering committee is to formulate, review, and recommend procedures, committee membership, and policies. Its recommendations are submitted to the Nutrition Council for approval.

The scientific advisory committee is charged with determining the accuracy of any material which is presented for publication. This committee is composed of a member of the Medical Association of Georgia, a staff member of the Georgia Department of Public Health, and a faculty member from the University of Georgia School of Medicine.

In addition, a public-health-relations committee has been appointed. The duties of this committee include the preparation of articles for public information.

The fourth committee is concerned with food production and program planning. This committee is composed of extension economists, representatives from United Georgia Farmers and Horticulturists, nutrition chemists, poultrymen, home-demonstration agents, Farm Security Administration representatives, animal husbandmen, county agents, and the State supervisor of home economics. It is felt that, from

this particular group, sound planning for food production can be formulated. The recommendations of this committee were as follows:

1. That all available information showing the value of food production in increasing income and in protecting health and preventing disease be made public in popular form for widespread distribution in newspapers, through radio and public speeches, and in discussion groups.

- It is recommended that a committee representing each phase of food production be appointed to review all information on home food production and to arrange to make it available in popular form.

2. That the economic value of food produced on the farm for home consumption be emphasized as a cushion to absorb the shock of reduced income from cash crops and that this information on economic value be made available in popular form.

3. That demonstrations in food production continue to be established and used widely by all groups as a source of information.

4. That because of the pressing need for nutrition in national defense a program for food production be included in all county agricultural programs.

5. That, in order to reach people who are at present not availing themselves of the opportunity to get all information and assistance in planning for and producing their own food supply, each farm person who is a member of any formally or informally organized group be urged to contact five or more other farm families on home food production.

6. That a greater effort be put forth by all agencies working with farm people to help those who are able to work to learn to help themselves.

7. That those who are getting relief assistance of any kind from the Government be required to have a garden when their physical and living conditions will warrant it.

8. That since the National Government is assisting farm people through benefit payments to make adjustments in agriculture, a sizable portion of these payments be used to encourage greater production of food on the farm through the purchase of garden seed, fruit trees, family milk cows, poultry flocks, and other productive livestock for home consumption.

9. That a separate and distinct fund be set up by the Agricultural Adjustment Administration for each farm, which can be earned only through the production of foods for home consumption. That since there is a penalty under the present AAA program to protect the land, a penalty should also be provided to protect the people by insuring the production on the farm of foods for home consumption.

The fifth committee is concerned with food preservation and food preparation. Its membership includes home-demonstration agents, home economists on food preservation and utili-

zation, a member of the Experiment Station, horticulturists, representatives from the Work Projects Administration, staff member from the Georgia Department of Public Health, and others. The point of attack by this committee was outlined as follows:

1. Review the community cannery facilities in the State as a basis for recommendations for better service.
2. Urge the various agencies to increase their stress on home canning projects.
3. Prepare recommendations for foods which may be dried with minimum loss of food value.
4. Study other methods of food preservation which conserve food values and may be recommended for use.
5. Assemble information on the freezing plants in the State which have storage facilities and determine to what extent they may be expanded.
6. Prepare instructions for food preparation to conserve food values.
7. Plan to make possible an increased number of food-preparation demonstrations in which the chief objective is conservation of food value. To include surplus commodities in the plan would be an added advantage.
8. Conserve used containers.
9. Emphasize need of checking canning equipment.

The sixth committee is concerned with school lunchrooms and nutrition teaching in schools. The membership of this committee includes the nutritionist from the Georgia Department of Public Health, the Work Projects Administration State lunchroom supervisor, a school teacher, the president of the Georgia Congress of Parents and Teachers, the State supervisor of schools, the State supervisor of home economics, a member of the Women's Auxiliary of the Medical Association, the president of the State Federation of Women's Clubs, the director of the Surplus Marketing Administration, and a home-demonstration agent. This committee has reviewed the situation and has offered the following as problems and objectives:

1. Home-economics classes could can products from school gardens.
2. Community canneries could also be used by schools for canning these products.
3. The school children could bring jars from home.
4. Gas and electric companies could be asked to donate, or sell at minimum cost, stoves which have been traded on new ones. Many of these stoves are in excellent condition and could be utilized by schools unable to purchase new equipment.

5. School-lunchroom equipment could be built by the following: National Youth Administration workshops; manual-training classes in the schools; boards of education.

6. Home-economics teachers should instruct the lunchroom helpers in planning menus, preparing food, and similar activities.

7. Home-economics teachers in the counties could take the elementary teachers as an adult class for instruction in nutrition.

8. Instruction of lunchroom supervisors could be done by home-demonstration agents and home-economics teachers. The lunchroom supervisors in turn could train the Work Projects Administration cooks in their lunchrooms.

9. A State supervisor of lunchrooms would be of great benefit to the lunchroom program, if such an individual could be secured. The duties of such a person would be the promotion of school lunchrooms—the establishment of new ones and the supervision of those already in operation. The committee agreed that an appeal should be made to the Department of Education for the creation of such a position.

10. Families who can produce a surplus above their own needs could trade the surplus to the school lunchroom for credit in food tickets for their children.

11. Community canneries should be placed at the disposal of schools that have garden projects.

The seventh committee is concerned with food selection and food budgeting. This committee is composed of a member of the teaching staff of the home-economics school of the University of Georgia, the extension nutritionist, a delegate from the Farm Security Administration, a nursery-school delegate, and others. The problems concerned and the objectives are as follows:

1. Formation of a family food budget, based on minimum, adequate, and liberal incomes.
2. Preparation of food-selection score card.
3. A guide for meal planning to be entitled "Hints to the Menu Maker."
4. A guide for forming good food habits.
5. Preparation of a food-value primer.

The eighth committee is known as the committee on nutrition information. This committee is concerned primarily with disseminating to the public the information that the other groups make available. This committee is composed of the extension editor, a city-school supervisor of home economics, a member of the Board of Education, a newspaper columnist, a home-demonstration agent, the State 4-H Club leader, a delegate from the American Association of University Women, the director of the Georgia Public Forums, and a member of

the Farm Security Administration. We have, in the majority of counties in Georgia, county organizations composed of individuals who are concerned with all problems relative to rural life, and these county organizations, which meet at monthly intervals and plan according to their own local problems, will be utilized to the fullest extent in carrying out the recommendations of the various working committees of the Nutrition Council.

The ninth committee is concerned with nutrition and food establishments. Membership here is made up of a nutritionist from one of our largest universities for women, the State supervisor of home economics, the nutritionist from a large hospital, and others. This committee is concerned with college dining halls, restaurants, hotels, tearooms, and all public eating establishments. Its objectives are:

1. To encourage employment of trained personnel in commercial food establishments.
2. To encourage food establishments to print on menu cards guides for the selection of adequate menus. These guides might be entitled "Simple Balanced Menus." This has also been instituted in hospitals.
3. To promote visual education through slides, posters, and films on selection of foods.

The tenth committee is concerned with marketing, its membership being made up of extension economists, the director of surplus commodities from the State Welfare Department, a professor of agricultural economics, the president of the producers' cooperative exchange, a county agent, an extension marketing specialist, and the dean of the Department of Agriculture at the University of Georgia. This group has proposed the following program:

1. That the Georgia Experiment Station and other research agencies give consideration to an enlarged program of research in the field of food marketing.
2. That cities give attention to modernizing their produce-distributive system so as to eliminate some of the waste in commodities and time.
3. That State agencies assemble and publish market information, giving attention to reaching farmers and consumers.
4. That retailers change prices with changing supply so as to stimulate consumption, when supplies are heavy.

It is realized that public-health workers do not have a sufficient knowledge of nutrition with which to do effective teaching. Our first attempt to overcome this deficiency was an institute for public-health nurses which practically every nurse in the State attended. Secondly, the nutritionist has prepared for the public-health personnel a syllabus in which is incorporated the fundamental knowledge needed in order to be able to discuss intelligently subjects related to nutrition. Thirdly, the nutritionist through actual contact with people has been acquainting herself with the habits and customs of our population. As I previously mentioned, the nutritionist can hardly be more than a coordinator, and for this reason we feel that our efforts in the nutrition work should be toward bringing every public-health worker into the program, so that all will be spreading the gospel, rather than one individual. I would recommend consideration of this question: Do the average public-health trainees, both nursing and medical, receive sufficient nutrition indoctrination in their courses to fit them for their field work? I can think of no better teaching to which public-health personnel could devote their efforts.

Nutrition Services in a County Public-Health Program¹

By A. F. WHITSITT, M. D., M. P. H.

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To get at the nutrition problems of any county and their relationship to public health we should first get a picture of that county.

Kent County is located in the upper part of that strip of land known as the Eastern Shore of Maryland, a rich agricultural section. It is bounded by water on three sides, and much of its history and activities bear significance to its water relationships and easily cultivated, fairly fertile soil. Kent was first mentioned as a county in 1642, when "Giles Brent was named as commander of the Isle and County of Kent" by Lord Baltimore. In 1942 we shall celebrate the three-hundredth anniversary of its founding. Kent is a county rich in the history of the Revolutionary War period, when the main means of livelihood seems to have been seafood industries and tobacco raising for old records show that teachers and preachers were paid in so many pounds of tobacco. Tobacco is no longer cultivated in Kent County, but its former importance as a money crop accounts for our large Negro population of the present time. Today the seafood industries still constitute a source of livelihood for people living along the bay, but more than one-third of the population live on farms and their livelihood is gained from the following, in order of their importance: Dairying, poultry raising, wheat and corn raising, and truck farming.

Kent County consists of 180,480 acres, of which 87.7 percent is in farms. According to the 1940 census the population of Kent County is 13,500. Of this number 31.2 percent are Negroes, and these had 42 percent of the births and 50.2 percent of the deaths during the last 10 years. The total population has been decreasing approximately 5 percent during each of the last 2 decades—the more ambitious of the

Negroes, who sought higher wages in the cities, being only partly replaced by an incoming white population.

One might think that Kent County would have little need for work along nutrition lines, but this is far from being the case. In 1934 a survey was made of all the Negro families in Kent County, under the direction of the board of education, the welfare department, and the health department. They reported only 10 families with incomes adequate for food, clothing, and shelter, according to the minimal standards set up at that time. Conditions among the Negroes are little better today.

During the past 2 years we have tested the hemoglobin content of the blood of all prenatal patients and have found that at their first visit more than 70 percent of the cases have been in the classification "border-line nutrition to frank anemia," according to Tallqvist's scale of testing. The prenatal patients come from all over the county and are seen by the obstetric consultant of the Maryland State Department of Health at our monthly clinics. Nine-tenths of the prenatal patients are Negroes, and all are in the low-income group. In 1940, 19 patients, out of 62 examined by the consultant, were found to have a contracted pelvis, which is caused by malnutrition. Study of the food habits of these patients by the State nutritionist and our staff nurses reveals that the main articles of diet are hog meat, white bread, potatoes, corn sirup, cabbage, and dried beans. Noticeably absent are milk, butter, eggs, green vegetables, and fruits.

In the areas of the county where the people are wholly dependent on fishing, crabbing, and oyster-tonging for a livelihood the standard of living is very low, and a very large proportion of the children are below the average weight for their height and age.

¹ This paper is one of a series presented at the Conference of State Maternal and Child Health Directors with the Children's Bureau, Washington, March 24 to 26, 1941.

County Agencies for Dealing With Nutrition Problems.

There are several agencies in Kent County, as in all counties, through which nutrition problems may be attacked.

First of all, there is the welfare department, which works with people with little or no income. In Kent the relief load is held to a bare minimum now. After the 1934 survey in which all but 10 colored families were classified as "on relief," 1 pint of milk was distributed to all colored school children and to a few needy white children each school day. This program was discontinued at the end of the school year.

The county Red Cross for several years following 1929 furnished a nutritionist for 8 weeks to follow up those children in the schools said by the health department to be malnourished. This agency has not been active in nutrition work in the county in recent years.

The Maryland Children's Aid does a creditable piece of work with 20 children placed in foster homes.

The county home-demonstration agent has 11 women's clubs organized, with about 350 white families represented. These families would be considered as a middle-income group and received much aid from the Extension Service as to budgets, planning family gardens, canning, and the like.

The home-demonstration agent and the parent-teacher association plan a canning program every September. The school children play a large part in this program, as they bring the vegetables to the school and prepare them for canning. This program was carried out in seven schools for white children. In the Negro schools the canning program is planned by the school teacher and put on with the aid of the older pupils.

Of all the agencies for working out a nutrition program for a county, the health department is the logical medium through which all nutrition activities may be coordinated. The health department is the one agency interested in all ages and all groups. It has been said that the welfare of each individual from the time of his conception till his death should be the concern of a health department.

Kent County deems itself fortunate in having had a full-time health service for the past 10 years. Our regular staff at the present time consists of a full-time health director, 3 general public-health nurses (1 of them is a Negro and has been with the department since 1927), a recently acquired nurse-midwife, a sanitary engineer, and a secretary. We also have a part-time dentist for the dental program and 2 National Youth Administration secretary-assistants. With this staff we are able to carry on a fairly intensive public-health program in communicable-disease control, sanitation, and education.

Nutrition Activities in Which Health Department Plays a Primary Role.

The nutrition activities for which a health department is solely or primarily responsible are essentially educational in nature. During the past 3 years we have had a prenatal clinic conducted once a month by an obstetrician from Johns Hopkins Hospital. Approximately 30 percent of the prenatal patients of the county have been seen during that period in our clinics. The State nutritionist visited our county with the obstetrician each month for the first 9 months of this period. She conducted nutrition conferences with the prenatal patients and with the staff nurses. Nutrition demonstrations were made by the nutritionist, and since that time the regular staff nurses or the nurse-midwife have taken over these conferences and demonstrations in the clinics.

These conferences are of benefit, but the best place to teach nutrition is in the home. Our nurses spend a good part of their time in home visiting. Our county is divided into two sections, with a nurse responsible for the generalized nursing program in each. The Negro nurse assumes the same duties among the Negroes. But her nursing load has been diminished, since the nurse-midwife takes over the general nursing program in those homes where there is a prenatal case.

I have stated previously that on their first clinic visit more than 70 percent of our prenatal patients were found to be anemic. By the furnishing of ferrous-sulphate tablets to needy patients and by diet advice, we have been able

to correct most of these deficiencies before delivery. Pamphlets for prenatal patients, from the State Department of Health and the Children's Bureau, are displayed and distributed.

Kent County has 13 practicing physicians. Most of them refer the mothers of children whom they deliver to our well-child infant and preschool health conferences for instructions in feeding. The health director, as the county registrar, is notified within 4 days of the birth of a child by his local registrars, and thus the district nurse is able to visit the infant within a week of birth.

Two monthly and four bimonthly child-health conferences are held in various parts of the county by the health director for the white people. The Negro nurse and the nurse-midwife hold six regular monthly child-health conferences, which the health director attends every other month. Food demonstrations are made and nutrition talks are given to mothers at these clinics. During Negro Health Week and the annual pilgrimage of the State Healthmobile, additional infants and preschool children are seen. The Kent County Tuberculosis Association furnishes cod-liver oil free for part of the needy group.

Nutrition Activities in Which Health Department Plays a Secondary Role.

The school health program is a cooperative endeavor.

In September of 1938 the home-demonstration agent of Kent County came to the health department and stated that she had accomplished about all she could alone and that she needed help with the school-lunch program. Since this was a part of our generalized program we were anxious to give as much help as possible. Up to this time only two schools had adequate school-lunch programs although several schools carried on a program for 1 or 2 months of the school year. Many sections of the county would not accept the valuable aid that the home-demonstration agent offered. The health department staff began immediately to do more intensive educational work concerning adequate diets for school children.

A survey revealed that families able to provide ample protective foods may have food

habits that are just as contributory to malnutrition as the inadequate food budgets of the lowest-income group.

A nutrition institute was arranged. The State nutritionist gave illustrated talks and demonstrations to all the parent-teacher association units in the county. For a week these meetings were held morning, afternoon, and evening at various places in the county. The nutritionist provoked a lively interest in the subject of adequate diet and the comparative values of various foods.

It was found in several schools that the assistance of the nurse was not necessary, as the teacher had taught the community the value of hot food at noon.

Surplus commodities were a big boon to the lunch program in the schools for white children but were the core of the program in the schools for Negro children. They guaranteed to the many children who had no breakfast at all or an inadequate breakfast and no lunch, a hot noon-day meal at least. Kent County was among the few that received commodities on a country-wide basis in 1939 and 1940. There were 1,870 children fed during this period.

The commodities received were:

Ham.....	pounds..	2, 422
Canned milk.....	cans..	9, 570
Canned peaches.....	do....	10, 420
Potatoes.....	pounds..	8, 100
Butter.....	do....	2, 880
Corn meal.....	do....	3, 630
Graham flour.....	do....	2, 610
Wheat flour.....	do....	8, 284
Oranges.....	do....	13, 520
Apples.....	do....	27, 620
Lard.....	pounds..	3, 085
Prunes.....	do....	2, 050
Raisins.....	packages..	2, 740
Eggs.....	dozens..	2, 694
Salt pork.....	pounds..	437
Whole-wheat cereal.....	packages..	2, 098
Rolled oats.....	pounds..	880
Dried beans.....	do....	2, 095
Rice.....	do....	1, 280
Bacon.....	do....	1, 291

In addition to these commodities, the parents donated milk, cabbages, potatoes, turnips, carrots, and also the ingredients needed to produce gingerbread, graham muffins, and so forth. Until the fall of 1940 the teachers donated the piece of meat for the soup.

The program in the schools for white children is handled in some places by the teacher and boys and girls in the 4-H Club, in other parts of the county by a paid worker living in the neighborhood, but in most of the schools it is a parent-teacher association project. The food, cooked at home and carried to school in large containers, is served by the parents and teachers.

The program in the schools for Negro children is a teacher-pupil program—directed by the home-economics and the agriculture teachers. The New Farmers of America, a group of 60 high-school boys, had 30 garden projects, 30 chicken projects, and 10 hog projects. Of the 60 families represented in this group only 6 have their own cows. The girls in the home-economics group can the vegetables raised in these gardens and all through the school year plan and prepare the school lunch for the one high school for Negroes in the county; however, in the elementary schools the program is conducted by the teacher with the help of the older pupils and National Youth Administration workers.

The county superintendent of schools states that the attendance record in Kent schools has been above the average for the past 2 years. The teachers report fewer colds, or very mild colds lasting only a day or so.

This year all the schools for white children, except 2, and all the 12 schools for Negro children have hot-lunch programs.

Indications of Progress in Nutrition in Kent County.

The prenatal patients of Kent County are very gradually learning the importance of diet both for themselves and for their unborn children. There is a marked increase in the numbers of infant and preschool children under the supervision of the medical and nursing services. Preceding the last 2 years Kent County had one of the highest infant death rates in Maryland. Now the county has one of the lowest.

Mothers are becoming more and more "food-conscious" for they are using in the home foods they learned about in prenatal and child-health conferences.

The Negro teachers, especially, report that their pupils are more alert and show a keener interest in school work. The white school children are showing interest in food variety to the extent of planning daily menus of well-balanced meals.

During the past 3 years the number of plants for pasteurizing milk in the county has been increased from one to three, and the number of quarts of pasteurized milk distributed daily has been increased from 654 quarts to 1,710 quarts.

Of first importance is the fact that each public-health nurse in Kent County has become a nutritionist, or at least a competent "seminutritionist," in that approximately half her time is spent in nutrition work.

Bolivia Bureau of Nutrition

A Bureau of Nutrition has been established this year in the National Department of Labor, Health, and Social Welfare of Bolivia. The Bureau will study the food habits of the people and the relation between food and health; it will collect statistics on the production, supply, and consumption of foods, and will prepare

nutrition standards for children, expectant mothers, and other groups of the population. It will also work for the improvement of the food in children's institutions and for a more extensive cultivation of wholesome vegetables and breeding of animals providing milk and suitable meat.

(Bureau correspondence.)

BOOK NOTES

Bibliography The Society for Research in Child on *pediatrics* Development has issued a *Pediatric*

Bibliography compiled by A. Graeme Mitchell as Vol. 6, No. 1, of Monographs of the Society for Research in Child Development (Washington, 1941, 119 pp. Processed. 75 cents). Titles on 10 general subjects and 82 specific diseases are included.

* * *

THE UNSEEN PLAGUE—CHRONIC DISEASE, by ERDST P. Boas, M. D. J. J. Augustin, New York, 1940. 121 pp. \$2.

In this compact little volume Dr. Boas presents a wealth of factual material and draws on his 20 years of experience in the field of chronic disease to give an analysis and discussion of it that he hopes may be used "as a basis for planning and action by government, community, and physician."

The first of the two sections is devoted to a discussion of the various aspects of chronic disease—its effects on the community and on family life; its medical aspects; and its social and economic aspects. The second section presents a community program of planning for the chronic sick and includes a detailed description of important features of a hospital for chronic diseases.

The material should be of interest to doctors, hospital administrators, public-welfare officials, community councils, social workers, and many others. Medical-social workers will be interested in the author's emphasis on the importance of treating both medical and social factors and especially in chapter 9, in which he discusses the interdependence of medical-social work and medical care. Professional groups working with crippled children will find especially interesting chapter 7 on children and the part of chapter 10 that deals with convalescent care, both of which give considerable

attention to children with orthopedic conditions and to those with rheumatic heart disease.

The author ends with a summary of the devastating effect of chronic disease and with an appeal for action, in the following words:

Chronic illness is a great, destructive force in society. It carries in its wake unemployment, destitution, neglect of home, neglect of children, disorganization of family life, and dissipation of community resources. Control of the inroads that chronic illness makes on the individual and on society can be made effective through comprehensive study and social planning.

M. W. K.

PEDODONTICS, by John C. Brauer, D. D. S., Kansas State Board of Health, Topeka, 1940. 31 pp.

This brochure, by the head of the Department of Preventive Dentistry and Pedodontics, College of Dentistry, Iowa State University, Iowa City, Iowa, is presented by the Kansas State Board of Health in cooperation with the United States Children's Bureau and the Kansas State Dental Association. It is based on a series of lectures to the dentists of Kansas on the potentialities and problems of dentistry for children.

MODO DE CUIDAR A LOS PACIENTES DE PARALISIS INFANTIL, by Jessie L. Stevenson. National Foundation for Infantile Paralysis, 120 Broadway, New York, 1940. 62 pp.

This is the Spanish edition of the pamphlet, *The Nursing Care of Patients With Infantile Paralysis*, which was reviewed in the March 1941 issue of *The Child*. Copies of this handbook may be obtained from The National Foundation for Infantile Paralysis, 120 Broadway, New York.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

The Hazardous-Occupations Program

An Administrative Function of the Children's Bureau

By ELIZABETH S. JOHNSON and SAUL WALLEN

Industrial Division, U. S. Children's Bureau

"To investigate, to report, and to administer—these are the specific functions of the Children's Bureau." Thus is summed up the job given the Bureau in considering as a whole the conditions, problems, and welfare of children. The organic act creating the Bureau directed it to "especially investigate * * * dangerous occupations, accidents and diseases of children."

Dangerous occupations and accidents to children have been the concern of the Industrial Division over many years and, since the enactment of the Fair Labor Standards Act of 1938 with its 18-year standard for work in hazardous occupations, this field has been a continuing and increasingly important activity of the Bureau.

From the time of the creation of the Bureau to the passage of the Fair Labor Standards Act, the Industrial Division investigated and issued a number of reports on hazards to employed minors, including industrial accidents. Studies of accidents to minors in various occupations and in a number of States were made. Unpublished statistics of accidents to young workers were collected and analyzed. At the recommendation of the 1930 White House Conference on Child Health and Protection, the Bureau appointed an Advisory Committee on the Employment of Minors in Hazardous Occupations. The report of this committee, prepared with the assistance of the Industrial Division, was published during 1932. These studies and reports resulted in the building up of a body of knowl-

edge and in the development of recommendations for the protection of youth in hazardous occupations and processes.

During the period 1933-35 the National Recovery Administration was the vehicle for translating the movement for better child-labor standards into action. Some three-fourths of the codes as approved contained provisions prohibiting the employment of minors 16 or 17 years of age in hazardous work. Most of them required that the code authority submit a list of such occupations to the National Recovery Administration, in order that the occupations and processes too hazardous for young workers might be clearly defined. Here again the "to investigate—to report" functions of the Bureau were fulfilled. On the basis of its research in the field of industrial injuries to minors, the Bureau assisted at the request of the National Recovery Administration in the designation of these hazardous occupations. About 175 such lists had been agreed upon by the industries concerned and approved by the National Recovery Administration before the operation of the codes was suspended. Because these code prohibitions were short-lived and because available statistics on accidents to minors were inadequate, it is impossible to evaluate accurately the effect of the hazardous-occupations provisions of the codes. At the very least, however, these code provisions and the Bureau's efforts directed the interest of many employer groups to the problem of protection of youth from industrial injuries and paved the way for the adoption by

the States of higher standards for the protection of young workers from employment in dangerous occupations.

It was not until the passage of the Fair Labor Standards Act of 1938 that the Children's Bureau was given the function of issuing orders regarding employment of minors in hazardous occupations. That act, which in effect establishes 16 years as the minimum age for general employment in establishments producing goods for shipment in interstate commerce, seeks also to protect workers between 16 and 18 years of age from employment in occupations "particularly hazardous for the employment of children between such ages or detrimental to their health or well-being. * * *." It provides that the Chief of the Children's Bureau "shall find and by order declare" such occupations to be particularly hazardous; such orders have the effect of establishing a minimum age of 18 years for the occupations they cover. The act and hazardous-occupations orders issued under it apply to concerns engaged in the production of goods which are shipped or delivered for shipment in interstate commerce. The enforcement of the child-labor provisions was placed in the Children's Bureau by Congress.

In administering the hazardous-occupations provisions the Bureau developed, with the advice of an Advisory Committee on Occupations Hazardous for Minors, certain basic principles. These are (1) that occupations particularly hazardous or detrimental to the health or well-being of workers in general are also particularly hazardous or detrimental to the health or well-being of minors under 18, and (2) that other occupations, not particularly hazardous or detrimental to the health or well-being of adult and experienced workers may nevertheless be particularly hazardous for minors under 18 because they require a degree of muscular coordination, stability, maturity of judgment, or resourcefulness in meeting emergencies not usually characteristic of young workers.¹ Over a period of time research methods and procedures in making determinations of hazardous occupations were developed. Investigations were

made of various occupations and industries on the nature and degree of the hazards of work in them. After consultation with representatives of employers and labor and with industrial experts reports were prepared and proposed findings and orders drawn up. Opportunity for objection and review was given interested parties at public hearings. Only after all these steps had been taken did the Chief of the Bureau issue final orders that declared the occupations covered to be particularly hazardous.

Notice of the issuance of the order is given through newspaper releases and notification to trade associations and unions, articles in trade magazines, and sometimes by mailing copies of the order directly to the employer.

It then becomes the task of the Industrial Division to administer and enforce these orders. Inspectors checking for compliance with the child-labor provisions of the Fair Labor Standards Act visit establishments covered by the act to see that no one under 16 years of age is employed in any type of work and that no one under 18 years of age is employed in occupations covered by hazardous-occupations orders. In order to protect employers from unintentional violation of the act, it is provided that they may keep on file certificates of age issued in accordance with regulations of the Chief of the Children's Bureau, showing that young workers are above the minimum ages established for the occupations in which they are engaged. Such certificates of age should be kept on file for 18- and 19-year-old minors employed in all occupations declared hazardous, as well as for 16- and 17-year-old minors in occupations not declared hazardous. Through cooperative plans developed by the Bureau with State departments of labor and education, State employment certificates or State age certificates are accepted in most States as proof of age under the act. Federal certificates of age are issued in the four States where State certificates are not available.

Since the Children's Bureau was charged with the administrative functions in the matter of hazardous occupations in October 1938, it has issued five hazardous-occupations orders. Each order covers occupations or industries in which there was believed to be a large number of young workers employed under hazardous conditions,

¹ For a full statement of the general principles formulated by this committee see *The Child*, November 1939, p. 136.

or in which the hazard was so great as to justify the erection of a standard that would prevent an influx of young workers into the industry when employment opportunities increased.

Order No. 1 is of the latter type. It has the effect of setting an 18-year standard in all occupations in or about any plant manufacturing explosives or articles containing explosive components. It became effective July 1, 1939.

The occupations of motor-vehicle driver and helper were covered by Order No. 2, effective January 1, 1940. In these occupations a considerable number of young workers were employed. In September of that year Order No. 3 became effective. It has the effect of barring youth under 18 from employment in all occupations in or about any coal mine, except the occupation of slate or other refuse picking at a picking table or picking chute in a tippie or breaker, and occupations requiring the performance of duties solely in offices or in repair or maintenance shops located in the surface part of any coal-mining plant.

Most recently issued and, like previous orders, carefully documented with reports of investiga-

tions, are Orders No. 4 and 5. They become effective August 1, 1941. Order No. 4 covers all occupations in logging and all occupations in the operation of any sawmill, lath mill, shingle mill, or cooperage-stock mill, with certain exceptions. Order No. 5 applies to occupations involved in the operation of power-driven woodworking machines.

Investigations are now under way of the hazards of shipbuilding and ship-repairing employments and of the hazards of metal-working machine employments for young workers.

In developing concrete standards governing the employment of minors in hazardous occupations and in enforcing these standards under the child-labor provisions of the Fair Labor Standards Act the Children's Bureau fulfills the triple function laid upon it—to investigate, to report, and to administer. Under that act the Bureau has been able to develop and apply the principle that, in this period of rising employment opportunities, young workers should be given safe jobs and the more hazardous jobs should be left for workers more experienced and better able to cope with their dangers.

Florida Enacts a New Child-Labor Law

The new Florida child-labor law, effective July 1, 1941, materially raises child-labor standards in Florida and places this Southern State among the more progressive States in child-labor legislation. The new law extends the occupational coverage of the former law, which applied only to specific establishments including factory and store employment, to any gainful occupation with limited exceptions. Both farm work and domestic service in private homes are exempted from all requirements of the act, except the minimum-age standard. The minimum-age standard covers domestic service in private homes and farm work during school hours, except when performed by a minor in connection with his own home and for his parent.

The basic minimum age for employment in this State is raised from 14 to 16 years, the 16-year standard being established for work at any time in any factory, workshop, mill, mechanical

establishment, or laundry. A 16-year minimum-age standard is established also for all employment during school hours, except farm work and domestic service performed by a minor for his own parent in connection with his own home. Florida thus becomes the fourteenth State to set a basic minimum age of 16, which is the standard set by the Fair Labor Standards Act of 1938.

The new law requires certificates for the employment of minors up to 16 years of age in all gainful occupations except farm work and domestic service. It makes mandatory, for the first time in this State, age certificates as a condition for the employment of minors between 16 and 18 years of age, which formerly were issued only on request. Employment and age certificates are to be issued under conditions specified in the 1939 School Code.

Hours-of-work standards have been strengthened for minors under 16; the former maximum

9-hour day, 6-day week, 54-hour week in specified occupations is reduced to a maximum 8-hour day, 6-day week, 40-hour week, and coverage is extended to any gainful occupation except farm work, domestic service, and street trades. On days when school is in session the hours of work of any child under 16 years of age when combined with hours in school may not exceed 8. A lunch period of not less than 30 minutes is required for employed minors under 18 years of age. Like the maximum-hours regulation, the occupational coverage of the night-work prohibition for minors under 16 is widened and the former prohibition of work between 8 p. m. and 5 a. m. is extended to include the hours between 8 p. m. and 6:30 a. m. Night work is prohibited also for minors under 18 years of age between 10 p. m. and 6 a. m. Minors between 14 and 18 years of age, however, are permitted to appear in theatrical performances or concerts up to 11 p. m. Under the former law there had been no night-work regulation for minors between 16 and 18 years except for messengers.

The former provision regulating street trades is made State-wide, instead of being limited in application to cities of 6,000 population or more; the 10-year minimum-age standard for boys engaged in selling was not raised but now applies to both selling and distributing and also to

bootblacking. The minimum age for girls engaged in street trades is raised from 16 to 18. The new law further prohibits boys under 16 from working during hours when the public schools are in session or on any day after 7 p. m. (8 p. m. April 1 to September 30). They may, however, begin work as early as 3 a. m.

The new act strengthens the protective measures against employment in hazardous occupations. It prohibits employment of boys under 16 and girls under 18 years of age as messengers for telegraph, telephone, or messenger companies and employment of both boys and girls under 16 in the operation of any power-driven machinery. It also establishes a minimum age of 18 for employment in a number of specified hazardous occupations, including substantially all the occupations which up to the present time have been declared particularly hazardous for minors 16 and 17 years of age by orders issued under the child-labor provisions of the Fair Labor Standards Act. Employment is prohibited under 18 also in occupations determined to be hazardous by the State Labor Inspector.

The act further includes provisions strengthening administrative procedures. Enforcement remains in the hands of the State Labor Inspector.

Florida Laws of 1941, S. B. No. 251, approved June 14, 1941; effective July 1, 1941.

Redesignation of States

Forty-four States, the District of Columbia, and Hawaii have been redesignated as of July 1, 1941, for the period ending June 30, 1942, as States in which State employment and age certificates are accepted by the Children's Bureau as proof of age under the Fair Labor Standards Act of 1938. Puerto Rico was redesignated for a period of 3 months pending the working out of details in the certificate-issuance procedures. The Children's Bureau now accepts State certificates in every State except the 4 in which

Federal certificates of age are issued: Idaho, Mississippi, South Carolina, and Texas. Temporary Regulation 1-A extended to 1-J applies to Alaska, where employers will continue to be protected from unintentional violation of the child-labor provisions of the Fair Labor Standards Act by having on file a birth certificate or a baptismal certificate for each employed minor that shows him to be of legal age for the occupation in which he is employed.

BOOK NOTES

YOUTH WORK PROGRAMS; PROBLEMS AND POLICIES, by Lewis L. Lorwin. Prepared for the American Youth Commission of the American Council on Education, Washington, 1941. 196 pp. \$1.75.

This study of public youth-work programs is based on the Federal youth-work programs now in operation in the United States—the Civilian Conservation Corps, the Work Projects Administration (in its employment of persons under 25 years of age), and the National Youth Administration. In May 1940 these three programs employed almost 1,300,000 youth, including about 900,000 young men and 400,000 young women. Of this number, 273,681 were employed by the Civilian Conservation Corps, 242,615 by the Work Projects Administration, and the remainder by the National Youth Administration. The National Youth Administration is the most important of these programs, since the Civilian Conservation Corps is more limited in scope and the Work Projects Administration gives little special training for the youth among its employees. This study is, therefore, concerned for the most part with the National Youth Administration.

The study deals with the problems and policies involved in a publicly operated work program for youth and attempts to suggest lines along which it might be developed. The questions raised are: What should be the purpose and character of a public work program for youth, and how should it be planned and carried out? Mr. Lorwin points out that some phases of these questions are now being answered as much on the basis of military considerations as on that of the need for youth training and employment. Other questions are still open to debate, but the arguments for or against

any particular solution are overshadowed by the supreme issue of national preparedness. He suggests that in view of the concentration of interest on national defense, the planning of youth-work programs presents three aspects: first, the meeting of the immediate demands of national defense; second, the preparation for industrial and economic dislocations and transformations due to the defense program; and, third, the call for psychological and social adjustments involved in preparing youth physically and emotionally for defense action and in educating them about the social aims involved in this action.

In connection with the need for meeting the immediate demands of national defense and of preparing for the economic dislocations that will follow the defense program, Dr. Lorwin maintains that "the most important problem is that of giving such training to the youth as will meet not only immediate but long-run trends." The tendency now is to gear the youth-work-training program to the need for special types of skills in defense production. This emphasis may result in more young people being trained for specialized jobs than can later be absorbed in the labor market. Another equally important problem is that of the need for an adequate educational program in connection with national defense. Youth in training should be offered "a program of general education in the aims of the national-defense program and in the national and international conditions by which it is shaped." Such a program would contribute to a valuable permanent educational plan for youth as well as meet national-defense needs.

B. S.

• EVENTS OF CURRENT INTEREST •

CONFERENCE CALENDAR

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|---------------------|---|------------|--|
| Sept. 15-18 | American Legion, Child Welfare Division of the twenty-third national convention, Milwaukee, Wis. Director of National Child Welfare Division: Emma Puschner, 777 North Meridian, Indianapolis, Ind. | Oct. 14-17 | American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York. |
| Sept. 15-19 | American Hospital Association, Atlantic City, N. J. Permanent headquarters: 18 East Division Street, Chicago, Ill. | Oct. 20-24 | American Dietetic Association. Twenty-fourth annual meeting, St. Louis, Mo. Information: American Dietetic Association, 185 North Wabash Avenue, Chicago, Ill. |
| Sept. 29-
Oct. 3 | National Recreation Association. Twenty-sixth National Recreation Congress, Baltimore, Md. Information: National Recreation Association, 315 Fourth Avenue, New York. | Oct. 27-31 | American Dental Association. Eighty-third meeting, Houston, Tex. Permanent headquarters: Chicago, Ill. |
| Oct. 6-10 | National Safety Council. Thirtieth National Safety Congress and Exposition, Chicago, Ill. | Nov. 11-14 | Southern Medical Association. Thirty-fifth annual meeting, St. Louis, Mo. Permanent headquarters: Birmingham, Ala. |
| Oct. 9-11 | American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill. | Nov. 14-15 | Child Study Association of America. Two-day institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York. |

Herbert Collins Parsons

Throughout the history of the Children's Bureau, Herbert C. Parsons, director of the Massachusetts Child Council, has been a guide, philosopher, and friend. His death on May 23 leaves a vacancy in the ranks of those upon whom the Bureau has always depended for wise counsel and inspiration. Mr. Parsons was born in Northfield, Mass., January 15, 1862. After a public-school education, he was engaged in newspaper work, studied law, and was editor and publisher of *The Greenfield Record* and editorial writer for the *Christian Science Monitor* until he became State Commissioner of Probation. After 20 years of service in the field of probation, he resigned at the age of 70 to devote himself to work for the welfare of children. As director of the Massachusetts Child Council he continued his active participation in National, State, and local organizations.

From 1896 to 1899 Mr. Parsons was a member of the Massachusetts House of Representatives and of the State Senate and was vitally interested in legislation in behalf of dependent and

neglected children during this important period of the development of protective functions by the Commonwealth. One of his last services for children was in connection with measures before the legislature of 1941. His journalistic instinct found expression in recent years in a delightful history of his native Northfield, entitled "A Puritan Outpost," which was published in 1937.

An editorial in the *Boston Globe* included the following understanding estimate of Mr. Parsons' character and his contribution:

In Herbert Parsons the Yankee strain ripened in mellowest spirit. He was the noblest example of the social worker in this community in his generation. The humanitarianism of Massachusetts found in him its largest, wisest, most practical service. All the generous labors of his life were nourished by his high faith in human nature. His own roots went deep into the common life. . . . To the last of his life he labored for more humane dealing with the failures of society, especially juveniles. Warm, friendly, humorous, shrewd, he took leadership gently. One of the high resource of his own nature, he eased the way for a multitude who needed a lift.

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UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives **THE CHILD**.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, **THE CHILD**, Children's Bureau, United States Department of Labor, Washington, D. C.

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the

CHILD

*** Monthly Bulletin ***



THESE CHILDREN ENJOY NURSERY SCHOOL WHILE THEIR PARENTS WORK

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

AUGUST 1911



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Program for Care of Children of Working Mothers

THE CARE of children whose mothers are being drawn into employment as a result of the defense program was the subject of a 2-day conference held at the Children's Bureau, Washington, on July 31 and August 1, 1941. The conference was called by Katharine F. Lenroot, Chief of the Children's Bureau, who is Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities. In this capacity she is responsible, through the Children's Bureau, for assisting the Coordinator in planning for the protection of children during the national-defense emergency.

The conference heard reports from Charles P. Taft, Assistant Coordinator of Health, Welfare, and Related Defense Activities; Col. Frank McSherry, Director of Defense Training; Mary Anderson, Director of the Women's Bureau; and Martha M. Eliot, M. D., Associate Chief of the Children's Bureau, who visited England last winter as a member of a Civil Defense Mission and whose particular concern was with measures for the protection of children. Members of the conference reported and discussed the situation as it is developing in the various parts of the country, the forms of day care for children that should be provided, and the coordination and development of community day-care programs and services.

The committee on statement of principles, headed by Paul L. Benjamin of the Council of Social Agencies, Buffalo, N. Y., drew up a 10-point program which was adopted by the conference in the following form:

We recognize the extreme importance of national defense, and the necessity of maintaining the demo-

cratic way of life which makes successful defense imperative. Toward this end we believe that every effort should be made to safeguard home life, to strengthen family relationships, and to give parents a direct opportunity to participate in community planning.

1. In this period when the work of women is needed as an essential part of the defense program it is more than ever a public responsibility to provide appropriate care of children while mothers are at work.

2. The conference group on the Provision Needed for Daytime Care of Children of Working Mothers urges that every effort be made to maintain standards that have been achieved relating to the employment of working women and to extend these standards where they fail to provide safeguards generally recognized as essential; and recommends that a joint meeting of the Labor Advisory Committee of the Women's Bureau and a committee representing this group be held in the near future to discuss how these standards may be maintained and extended.

3. The welfare of mothers and children should be given due consideration at every point in the development of employment policies relating to national defense. Mothers who remain at home to provide care for children are performing an essential patriotic service in the defense program.

4. Advance information concerning plans for increased employment of women should be made available to community agencies in order that parents, public and private agencies, schools, and industry may plan together for the care and protection of children.

5. Working mothers who cannot make arrangements for adequate care of their children by relatives or friends must rely upon nurseries, child centers, and other forms of community day care. Community plans for the care and protection of children of working mothers should include as many of the forms of day care as are required to meet needs of children of all ages for whom such provision should be made. These activities should be integrated with the whole community program for public and private family assistance, social services to children, health protection, education, and recreation.

Included in such plans, individual counseling service provided as part of a unified community program should be available for mothers planning to enter employment or already employed. The object of this service is to assist parents in making plans which will safeguard family life and make adequate provision for the health and welfare of parents and children.

6. Nursery schools, nursery centers, and cooperative nursery groups should be developed as community services, under the auspices of public or parochial schools, welfare departments, or other community agencies. They should not be located in industrial plants or limited to children of mothers employed in particular establishments. Infants should be given individual care, preferably in their own homes and by their own mothers.

7. The standards of personnel, equipment, procedure, and care generally recognized as acceptable by health, educational, and social organizations should apply equally to all types of nursery schools and day-care centers.

8. Other forms of care such as day care in foster homes, housekeeper service, day camps and vacation camps, leisure-time and after-school programs, and other types of service which may be developed, should be planned and conducted as part of a comprehensive community program. All such programs should be conducted in accordance with recognized standards which will assure qualified personnel and adequate service.

9. Federal and State agencies and national organizations have a continuing responsibility for exerting leadership in upholding standards of child care. These agencies have the further responsibility of stimulating action by local communities and assisting them in their

efforts to meet the increased demands for care and protection of children which have grown out of or have been augmented by the expansion of defense activities.

10. The development of the services needed to promote this program will require greatly increased personnel. We therefore recommend that careful plans be made for the selection, training, and supervision of competent workers in accordance with established standards.

After considering the problem of daytime care of children of working mothers in relation to other emergency problems of child protection—such as exploitation of child labor, mental hygiene, the possible evacuation of children, and problems that might arise as an aftermath of the emergency, the committee on plan of work, headed by Elizabeth W. Clark of the National Association of Day Nurseries, recommended the following plan for continuing committees, which was adopted by the Conference: An overall committee concerned with all phases of child care in connection with defense. A committee on care of children of working mothers with the following subcommittees: subcommittee on Federal-State responsibility; subcommittee on community planning for day care; subcommittee on standards and services for day care; and subcommittee on recruiting and training of personnel.

Citizen Responsibility

A Guiding Principle in Pennsylvania's Child-Welfare Services

BY ELIZABETH TAYLOR SHIPLEY

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The two regional conferences of the child-welfare services in Pennsylvania, held in May 1941 in the eastern and western ends of the State, were significant events. These two meetings were attended by approximately 158 persons from 19 counties participating in child-welfare services, among whom were 20 county commissioners from 9 counties, members of the State-wide advisory committee to the Rural Child-Welfare Unit of the State Department of Welfare (which administers child-welfare services in Pennsylvania), members of the advisory committees in the various counties, State and local staff members of the child-welfare services, and other interested persons.

These conferences brought together from widely separated rural areas county officials, State and Federal representatives, and private citizens, to spend a day of earnest and eager consultation on how each one in his own setting, and all of us together, might serve better the dependent and neglected children in our midst.

What was it that made this conference possible and what seems to have come out of it?

In Pennsylvania the tradition of the responsibility of the private citizen for the development and vitalizing of public-welfare services has been a long and honorable one. Although we have never fully lived up to this tradition, there has always been some leavening influence to keep us reminded of it. A brief review of the history of child-welfare work in Pennsylvania shows devoted individuals promoting the movement to remove children from almshouses and jails; starting institutions which they called "children's homes"; and later, recognizing that institutional homes could not take the place of family homes, starting child-placing organizations in order to build up a system of private foster care to supplement the care

given in the group programs. Growing recognition of the safeguards necessary in institutional or foster-home settings, of the value of the child's own home for him, and the emergence of our present-day concepts of what constitutes understanding and responsible care of dependent and neglected children, have all been due to the vision, insight, imagination, and courageous action of individuals who became leaders in the service of children in need of care. The Rural Child-Welfare Unit has included participation of private citizens and their sharing of responsibility with public officials as one of the bases on which the child-welfare services are built.

Under the provisions of the County Institution District Law of 1937, county commissioners became responsible for the care of dependent children—an obligation formerly lodged with local directors of the poor—and the State Department of Welfare was made responsible for the establishment of rules, regulations, and standards for the guidance of the county commissioners in the fulfillment of this task. Many of these county commissioners had had no former experience in administering direct services to persons in need, and in most of the rural counties there were no private child-caring agencies with recognized standards to which the county commissioners could turn for help or advice. In the development of the child-welfare-services program in the State, therefore, the Rural Child-Welfare Unit planned service to these dependent and neglected children, many of whom were already separated from their own homes, through helping the county commissioners to strengthen their own services. Federal funds made available for child-welfare services have been used to provide the county commissioners in 19

counties with county child-welfare secretaries equipped by personality, training, and experience to plan and care for the dependent and neglected children for whom the county commissioners must be responsible. County commissioners provide the costs of direct care (board payments, medical care, and clothing) for the children, and provide office space and equipment, transportation costs, and in some cases, stenographic service; sometimes, where case loads are high, they also pay the salaries of additional children's workers.

But such a program is very new in most of these counties, and county commissioners are often fearful of criticism of their "lavish" expenditures for the wards of the county. They need the understanding and backing of local citizens. Citizens of the county also need to understand the differences between a responsibility *responsibly* carried and the type of care formerly given in a hit-or-miss fashion, which at best had little but good will and intent to commend it and at worst meant exploitation or neglect of the small charges of the county. Therefore the practice of asking "lay" citizens to serve in an advisory capacity has been followed in the counties as well as in the State administration of the child-welfare services. Before the Rural Child-Welfare Unit enters into an agreement to supply the services of a child-welfare secretary in any county, a definite plan, which includes the setting-up and the use of an advisory committee of citizens, is signed by the county commissioners, the Secretary of Welfare, and the supervisor of the Unit.

As the program has developed, this citizen participation and sharing of responsibility has become a very real force in procuring for children the consideration which is their right. A State-wide advisory committee appointed by the Secretary of Welfare, and made up of persons who in their professional fields or in their private capacity have demonstrated a particular interest in children, discusses with the supervisor policies and plans for the development of child-welfare services throughout the State and works with the supervisor and the Secretary of Welfare on such problems as the establishment of a merit system, the annual plan and budget, and matters affecting the various counties. It

was this State-wide advisory committee that took responsibility for planning, with the Unit staff, for the regional conferences of the county advisory committees, and both of these conferences were attended by members of the State-wide committee, who took active and interested part in them.

At these regional conferences we could see for ourselves the relationship of mutual confidence and respect that is developing between county commissioners and committee members, as each committee reported on its own services. The chairman of one advisory committee reported:

Our relationship to the commissioners has been a happy one. The commissioners have given our group wide latitude in the selection of committee members. The commissioners have taken a vital interest in the program.

I feel much more certain now than I did 2 years ago of the necessity of having an advisory committee, and I begin to see more clearly the real help and the positive function of such a committee. So far as my own contacts in my own community have been concerned, the child-welfare situation had been positively barbarous and uncivilized. The commissioners have rendered a greater service than they realize by making this possible. The agency (the county child-welfare services) has established something new which represents a great step forward in our county.

As far as advisory committees are concerned, I believe it is our responsibility first of all to take pains to understand; second, to really care for the welfare of children; third, to defend such care given on high standards; fourth, to promote interest in such care; and, finally, to seek in every possible way to maintain the agency as one of the civilized forces in our community life.

The outreaching of the advisory committee in another county from the particular needs of children under the child-welfare services to a general need of children in the county was evidenced in another report:

A dental committee was appointed (as a subcommittee of the county advisory committee) to work with other groups toward the establishment of a dental clinic at the hospital, this clinic to be used by all of the children in the county needing its services. The chairman of the committee secured the information from the State Department of Health that it would pay \$40 per month for the services of an interne or dentist if the project were supported by a tax-receiving body such as the county commissioners. The Dental Society would be able to secure the equipment at a low rate. The chairman thought that there would be money avail-

able from different interested groups, and now it is a question of developing further interest and putting into shape something for which there is a great need and readiness on the part of the community to meet the need.

One committee reported that, "When Bryn Mawr College asked the county secretary to supervise one of their Austrian refugee students for a brief period, the committee, with the approval of the county commissioners, interviewed her and took responsibility for her coming here."

Still other reports gave evidence of the strength given by the committees to the county commissioners, when, against local political or financial pressures, they were honestly and sincerely "trying to be their best selves" in relation to the children for whom they have been given responsibility—whether the question was one of personnel, or of board for children, or some other problem. At other times the committees have demanded that their elected officials should face squarely responsibilities which they seemed to be evading and have thus won the respect

of the commissioners. This relationship has been reciprocal, and citizens who had little grasp of the pressures and responsibilities actually carried by the county commissioners have gained an understanding of the tasks which they themselves have placed upon their officials.

Reverberations since these regional conferences have proved their worth to those who took part. Advisory-committee members, formerly diffident about taking active part in county-committee meetings, have "spoken up" on the purposes or the extent of the child-welfare services throughout the country, or have cited reports given by other county communities suggesting constructive lines of service and hitherto unrecognized possibilities for action suited to the needs in their own counties.

All of us, I believe, renewed our courage and determination to go on together, in this Commonwealth of Pennsylvania, uniting our public and private efforts in the single purpose of serving each child and of promoting the welfare of all children in the State.

BOOK NOTES

PUBLIC RELIEF 1929-1939, by Josephine C. BROWN.
Henry Holt & Co., New York, 1940. \$3.50.

"During the 10 years between 1929 and 1939 more progress was made in public welfare and relief than in the 300 years after this country was first settled." This statement is in the foreword of Josephine C. Brown's chronicle of the decade 1929-39. This decade is described as the most important in the history of public assistance in the United States, as marking the development of new trends, philosophies, and programs, based on a revolution in social thinking in the area of public responsibility for those in need. Because of Miss Brown's connection with the Federal Emergency Relief Administration and the programs of the Federal Government during this period, she is able to present well-documented material and to picture the philosophies and ideologies permeating the programs from the point of view of a participant as well as a historical observer.

The book is divided into four parts. Part 1 traces the history of public relief before the depression of 1929, starting with the local Poor Laws inherited from England and proceeding through the growth of public relief agencies and the gradual acceptance of relief as a well-defined responsibility of local and State governments.

Part 2, entitled "Unemployment Relief 1929-1933," presents vividly the drama of a nation whose resources, industrial and human, had been disorganized by the onslaught of the country's greatest depression. Here is shown an aroused public opinion demanding Federal aid to help local communities and States meet the mounting costs of relief to the unemployed. The battle for Federal relief is seen against the background of conflicting ideologies and a long history of local responsibility.

Part 3, on the Federal Emergency Relief Administration, gives the history of two Federal relief and work programs—FERA and WPA—and describes the planning for the later programs of social security. Here are set forth the problems of administration of these huge programs, the philosophies, attitudes, and methods permeating the FERA and other programs during this period. This section of the book brings out the contributions to a permanent program made by the FERA: Its emphasis on high standards of personnel, administration, and assistance; its gesture in making funds available in its last grant for the training of personnel; the setting of the stage for a more permanent program.

Part 4, entitled "The Beginning of a Permanent Program: 1935-1939," describes the passage of the Social

Security Act, reorganization of the Federal agencies under the general reorganization plan of the Federal Government, and the growth of State and local public-welfare agencies under the impetus of grants-in-aid programs under the Social Security Act.

The appendix contains various memoranda and press releases of interest, as well as statistical and financial charts and tables. The bibliography in the appendix lists about 500 references.

C. I. S.

FEDERAL AID AND PUBLIC ASSISTANCE IN ILLINOIS, by Arthur P. Miles, University of Chicago Press, Chicago, 1941. 259 pp. \$1.50.

This is a study by Arthur P. Miles, assistant professor of social economics, School of Social Work, Tulane University, of public assistance in Illinois from the beginning of the Reconstruction Finance Corporation grants in the early period of the depression to the present day. The editor's note by Sophonisba P. Breckinridge points out that there will have to be many studies similar to this before all the lessons of this past decade of public assistance can be drawn. The introduction contains a brief but excellent statement of the system of "grants-in-aid."

Starting with the RFC, the study presents the experience of Illinois throughout the programs of Civil Works Administration, Federal Emergency Relief Administration, the pronounced effect of the withdrawal of Federal aid upon the dissolution of the FERA, and Federal grants-in-aid under the Social Security Act. In the final chapter of summary and conclusions the author recommends the establishment of a general-assistance program as part of the public-assistance provisions of the Social Security Act and makes various other recommendations including proposals relative to

the administrative set-up of public assistance in Illinois. As regards the Division of Child Welfare, he recommends:

"The division should be retained and strengthened within a department of social welfare. It should not only continue its present work but should have supervisory responsibility for an aid-to-dependent-children program. The protection and care of children differs considerably from the administration of outdoor relief for the unemployed, the blind, and the aged. Such services, although administered through the same State and county agencies as the other assistance programs, require separate supervision and local administration through specialized rather than so-called 'undifferentiated' case work."

Studies similar to this in every State would supply the gaps in current literature of Federal-State relationships in the field of public assistance since 1930 and would provide basic information for future planning.

GUIDANCE IN DEMOCRATIC LIVING, by Arthur D. Hollingshead, Ph. D. D. Appleton-Century Co., New York and London, 1941. 260 pp. \$1.80.

The origin of this book is traced to a quotation from Noah Webster, "If then the youth were to grow into citizens capable of furthering democracy, it must be by means of an education suited to a democracy." The book discusses a program for the utilization of the school situation as an opportunity for the students to acquire experience in managing their own behavior as individuals and as groups in ways designed to further the goals of democratic living. This program grew out of group thinking and experimentation on the part of the author and his teaching staff in 9 years of experience in an elementary-school setting.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

A State Nutrition Program From the Nutritionist's Point of View¹

BY CATHERINE M. LEAMY

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The Maryland nutrition program, under the direction of the Chief of the Bureau of Child Hygiene, was begun 3½ years ago and now employs the time of two nutritionists. The Bureau of Child Hygiene, one of the seven bureaus of the State Department of Health, carries on its activities in the 23 county health units in the State.²

Staff Conferences.

In planning and executing the nutrition program, the nutritionists have the advantage of a close relationship with the other members of the staff of the Bureau of Child Hygiene, namely the consultants in obstetrics and pediatrics, the nurse supervisors, and the consultant in maternity nursing. One of the important factors in this relationship is the weekly staff conference held by the bureau chief. At these conferences the activities of each staff member are reviewed, future plans are discussed, individual county activities that might affect staff activity are presented, and reports are given on related problems. These reports are particularly helpful because they enable the nutritionist to receive first-hand information of progress

of activity which had been started in a county. For example, one of the nurse supervisors might have visited a school cafeteria with which the nutritionist had worked, or the consultant in obstetrics might have observed the activities of a volunteer worker.

Staff conferences not only give the nutritionist the benefit of the experience of others but assist in enabling her to enlist cooperation in handling special problems. Recently a large amount of reference material on nutrition was prepared for the nurses to include in their notebooks. It was felt that a discussion of the material was necessary for its intelligent use. Obviously, it was impossible for the nutritionists to visit each county in the near future, so the nurse instructors assumed the responsibility of distributing the material in many of the counties, thus making available information which it would otherwise have taken nearly 6 months to disseminate.

Staff conferences facilitate program planning and prevent two members of the State staff from attempting special work in the same county simultaneously, as well as making occasional planning of joint activity most helpful. For example, the consultant in obstetrics introduced the nutrition program to a previously uninterested county through his prenatal clinics, thus making possible continuous nutrition service.

Another most vital result of the weekly staff conference is the appreciation of the aims, problems, and results of the programs of coworkers.

¹ This paper is one of a series presented at the Conference of State Maternal and Child Health Directors with the Children's Bureau, Washington, March 24-26, 1941. A limited number of reprints of this paper and of the papers by Dr. Edwin R. Watson (The Basis of the Nutrition Program, in Georgia's Department of Public Health) and by Dr. A. F. Whitsitt (Nutrition Services in a County Public Health Program), which appeared in *THE CHILD*, July 1941, will be available from the Children's Bureau on request.

² A brief account of activities developed in the early stages of the Maryland nutrition program was given by Miss Leamy in *THE CHILD*, April 1939, p. 231.

Without these conferences the work of integrating coherently the nutrition program with the other activities of the Bureau of Child Hygiene would seem most difficult.

Advisory Committee.

Another tie between the nutrition program and the other activities of the Bureau of Child Hygiene is the fact that a representative of each field in which the nutrition program functions is a member of the nutrition advisory committee. The members include the Bureau Chief as chairman, the consultants in obstetrics and pediatrics, the nurse-supervisor, the editorial assistant, and representatives from the State Departments of Welfare and Education, the University of Maryland, Johns Hopkins University, the State Extension Service, and the Maryland Children's Aid Society. The committee meets semiannually to review the nutrition program, make suggestions regarding future plans presented for consideration, and review material made available for publication. Each member is at the disposal of the nutritionists, on request, for individual consultation.

Although the advisory committee has been most helpful as a group, its greatest value has been that of relating the State nutrition service to that of other agencies. Through the State department of education it has been possible to expand the school-lunch program, carry on a joint adult-education program, and participate in round-table discussions with home-economics teachers.

The contacts with the University of Maryland's medical and extension services and with Johns Hopkins University have been the means of obtaining students and volunteer workers to give instruction in prenatal clinics, while the county home-demonstration agents have not only given nutrition service at the prenatal clinics, but have also organized groups to train lay leaders for clinic service, participated in joint class instruction, and arranged for group meetings at which the nutritionist speaks.

Through the State Department of Welfare the nutritionists have arranged to hold staff conferences with county welfare workers and have obtained surplus commodities for use in instruction of food preparation at prenatal

clinics, while the Maryland Children's Aid Society has arranged group meetings on nutrition.

Through its understanding of the aims of the nutrition program the advisory committee has been most active in stimulating the program throughout the State, a fact that has contributed much to its progress.

Relations With County Health Officers.

Although much planning is done before the nutrition service actually reaches a county, it is upon the county health officer that the actual execution of the program depends. Without his backing, little could be accomplished; without his advice, many pitfalls would be met. In Maryland each county is a separate entity—each has its individual problem. A State worker who starts on a State-wide program feels that the time will never come when these individual characteristics will be clearly defined in her mind, but it is early apparent that one plan will not fit 23 situations. For example, the activities which fit a county of 15,000 population scattered in an isolated, mountainous area with a few desperately poor mining communities, where there is a staff of 5 public-health nurses, few organized clinics, and no definite school-lunch program, will be vastly different from those of an adjoining county with a population of about 70,000 centered in a large industrial city—a county with a staff of 9 nurses, a supervisor, 2 physiotherapists, and an assistant county health officer, and with a highly organized clinic program in several health centers. The county health officer helps the nutritionist to interpret her program in such vastly differing situations, and often actually plans a detailed schedule of her activity which he sends to her a week before her anticipated visit. It is through the health officer that the nutritionist gains entree into various county organizations and activities. His backing is behind each new undertaking, and because of his backing and his presence at staff conferences many activities gain momentum and continue to be effective.

Program Adapted to Local Conditions.

Two counties may be mentioned to show how the nutrition program varies with the county situation. The program of a mountainous, rural county has been built around work with

other county agencies. Visits have been made to the one-room schools with the county supervisor of education to discuss with teachers ways of inaugurating a hot school lunch; two community groups were organized with the cooperation of the Work Projects Administration recreation leader, and with these groups a series of 12 classes were held in which the county home-demonstration agent taught nutrition, representatives of the county health department discussed health problems, and the recreation leader led games. Not only have staff conferences been held with the nurses, but many conferences have been held with the welfare workers. Family visits to demonstrate the teaching of nutrition have been made with both nurses and welfare workers.

In a second county with a larger staff and more extensive facilities, the nutrition program has been concentrated within the health-department group. Numerous staff conferences have been held; family visiting has been done on a demonstration basis with the nurses; nutrition service has been given both at well-child conferences and at prenatal clinics; and special meetings have been held with mothers whose children are under the care of physiotherapists.

In some counties the health officer feels that the school-lunch program is the first and best approach to meeting the nutrition needs of the county; in other counties the prenatal clinics seem the best medium through which to start nutrition work. In all counties the nurses are the most important channel through which nutrition information can be disseminated, and their interest and cooperation is most difficult to enlist unless the health officer appreciates the aims of the nutrition program and has a part in its planning and execution.

Certain Phases of the School-Lunch Program.

The school-lunch program has seemed of particular value as part of the State-wide nutrition program. In some counties, however, a problem has arisen in connection with cafeterias operating on a concession basis. It often happens not only that these cafeterias are managed by untrained persons but that they serve food which is undesirable though financially profitable. To overcome such situations, the health officers of

the two counties most keenly affected suggested a survey of their entire school-lunch program. The result indicated that the conditions which so definitely influenced the nutrition of the school child were caused by lack of knowledge on the part of the managers.

Through the cooperation of the Department of Education, it was possible to have a week's institute for school-lunch managers which included classes in cooking, cost accounting, food selection, sanitation, counter arrangement, and food service. The results have been far more gratifying than was anticipated. Some of the managers have completely rearranged and re-decorated their cafeterias to make them more attractive places in which to eat; all managers have emphasized the use of whole wheat and other dark breads, fruit, and simple desserts; some have reported a 33½-percent increase in their sales of milk, the discontinuance of the sale of soft drinks, and, most important of all, a new interest by the teachers in the cafeteria and its educational possibilities. This winter it was possible to have two follow-up meetings at which the managers reported their progress and the principals contributed to a round-table discussion.

A report of the school-lunch program would not be complete without mention of the important work the nurses have done in connection with it. They accompany the nutritionist on her annual visit, and then discuss with the manager and the school principal, the report of the visit. They constantly encourage the manager to follow the suggestions which are made and supplement the manager's work in interesting the teachers in the teaching of nutrition.

Because of the interest in nutrition teaching, and because of the fact that the teachers seem to have felt that it was difficult to obtain teaching material on nutrition, a teaching outline, "Nutrition in the School Lunch," was prepared for use in elementary schools. Two county supervisors of education volunteered to use the pamphlet on an experimental basis this year so that it could be revised and used on a State-wide basis next year. The results of the experiment have been excellent.

Another activity which is related to the school-lunch program, and which has been of

value in arousing both school and community interest in nutrition, is the survey. In one county the nurses undertook to survey the food habits of nearly 1,200 white children, in an effort to start a school-lunch program. The health committee members interviewed all the children in the first 4 grades. In grades 5 to 7, the children recorded their own daily intake. The results revealed in startling fashion the need for improving the diets of many children. The county now has a school-lunch program.

The school-lunch program has also been a means of cooperative activity with the county sanitarians, as the nutritionist has had the opportunity of making food-service inspections with the county sanitarians, and, in turn, they have participated in the school-cafeteria institute by contributing material on food preservation and dishwashing.

Correlation With Other Services.

One medium of nutrition activity has been the oral-hygiene program. In a county where preschool dental service is being conducted on an experimental basis, nutrition service has also been included. The material obtained in this manner has been carefully analyzed and correlated with the dental findings. As yet, however, the results show little conclusive evidence relating nutrition habits to dental decay.

A survey has been made by the nutritionist in which the diets of prenatal patients have been carefully analyzed on the basis of their food intakes recorded at a clinic interview. The results, which indicated, for example, that nearly 40 percent of the group had an intake of less than 1,000 calories a day, and that but 4 percent had enough iron, have been used widely in staff education, and have done much to stimulate demands for nutrition service at prenatal clinics.

Use of Volunteer Workers.

Because of limited nutrition service and because of the demand for the teaching of nutrition at prenatal clinics, volunteer service has been of primary importance. The use of student dieticians has been mentioned; in some counties it has been possible to obtain graduate dieticians or home-economics teachers who offer their services in addition to the services of a

home-demonstration agent. In still other counties, lay leaders assist in the program. In preparing the volunteers for their work, each worker is given a definite outline of the material to be presented at the clinics. Only people who have had training at food clinics are encouraged to conduct conferences with individual patients, and in all instances an effort is made to have the volunteer observe the nutritionist work in the clinic before the volunteer is started out on her own. In the county in which lay leaders are used, two all-day institutes have been held in which the nutritionist executes all the demonstrations which the lay leaders are to give.

Staff Education Through Clinic Interviews.

Although in many counties the clinic situations are not such that the nurse can spend 2 half days with a nutritionist, the clinic interview has proved a valuable method of staff education where it has been possible. The nurse spends the first half day observing while the nutritionist conducts the clinic conference. On the second half day the nurse conducts the conference and the nutritionist observes and gives suggestions. Such a procedure has proved far more valuable than a single staff conference.

Correlation With Adult Education Activities.

The adult-education classes conducted in cooperation with the Department of Education have also proved a valuable activity. The plan requires that the county health department organize the group and furnish both the equipment and the material, and that the Department of Education pay a teacher for 10 2-hour lessons. The communities in which this procedure has been particularly successful are those in which the population lives in a small area. The problems of transportation in an area where the population is scattered have yet to be solved to make the procedure equally successful in a rural district.

These are the most important phases of the Maryland nutrition program at its present stage of development. The program is being revised constantly to meet the individual needs of each of the State's 23 counties in the hope of eventually creating some permanent activity for each.

Some Parental Attitudes Toward Handicapped Children

BY ELLEN WHELAN COUGHLIN

Social Worker, Detroit Orthopaedic Clinic, Detroit, Mich.

Much has been written about the attitudes of parents toward their children, and it is generally agreed that these attitudes are the most powerful single factor influencing the development of the children's own personalities and their social relationships. The specific application of this to the particular problems of the handicapped child is not so well known, however, and it is a matter of intense interest to those who are dealing with this group of children.

It is natural to suppose that, since the family constitutes the area of most intense feeling, the presence of a handicapped child in the family group must have some special effect. The fact that the handicapped child requires a larger share of the attention, concern, personal services, and financial resources of his parents makes it impossible to disregard the handicap as a determining factor in the social relationships of the whole family. Since the child's attitude toward his handicap will be based on the example of those he sees about him, the importance of knowing as much as possible about the feelings of the parents could not be overlooked. For all these reasons an inquiry into parental attitudes toward handicapped children was begun in the Detroit Orthopaedic Clinic.

This agency, devoted to the care of handicapped boys and girls up to 21 years of age, introduced a mental-hygiene program 5 years ago under which qualified medical-social workers with child-guidance experience work intensively with selected cases.

From this selected group 51 cases in which both parents of the child were living and in which the case worker knew the attitudes of the parents were chosen for study. No children with cerebral palsy were included.

The patients selected were 5 to 20 years of age. Two-thirds of them were in the adolescent period during which handicapped children, like normal ones, face an intensification of their

problems. Slightly more than one-third were girls. Two were Negroes. All but three of the children came from homes in which there were other children. The parents were foreign-born, or the home was characterized by foreign cultural patterns, in more than three-fourths of the cases.

Financially the families were divided into three groups according to whether they relied on agency help entirely, partly and intermittently, or only as a result of the strain of serious illness. Because of the intake policy of the agency, even those whose resources came nearest to being adequate were in the marginal income group; nevertheless, about half of the families included might never have come to the attention of an agency had it not been for catastrophic illness.

All the children had serious orthopedic conditions. In 9 instances the handicap was present from birth; in 11, the illness occurred before the child was 2 years of age so that there would be no conscious memory of an earlier experience as a normal child; in 12 cases, onset of handicap occurred before 6 years; in 12 cases between the ages of 6 and 12; and in 7 cases between 13 and 15 years.

Only 3 of the 51 patients were totally handicapped, 28 were able to participate in some normal activities with special adjustment of environment, and 20 could fit into the life of physically normal people by making some modification of their activities and slight adaptations of environment.

Parental attitudes in the group studied were classified either as constructive or destructive. The attitude considered most constructive was that of the relatively small number of parents who had sufficient intellectual insight and were so well-adjusted personally that they were able, while fully realizing the implications of the orthopedic problem, to accept it and turn their

attention and energies toward finding means of compensating for it. A second group of parents had a sufficient intellectual grasp of the situation, and a wish that the child might have as many compensations as possible, but lost part of their effectiveness in finding compensations for the child because of their own emotional reactions to the problem. A third attitude, also classed as constructive, was that of the parents who accepted the child at his level of physical limitation, realizing his difference, securing treatment for him, and allowing the handicap to affect their relationship toward him, as a person, very little. More than half of the parents studied fell into one of these classifications.

On a still lower level but classified as constructive because of its effect on the child was the attitude of complete acceptance of a handicapped child on an emotional level with very little or no intellectual insight. This minimum awareness most often occurred among foreign-born parents, particularly those of dull mental ability. Some of the parents in this group ignored the need for treatment entirely because of failure to understand what could be accomplished, and others placed their problems in the hands of an agency with a childlike gesture of turning over responsibility and feeling no need to do anything further themselves. Often, however, this attitude of acceptance had no ill effect on the child because of his feeling of perfect security in the parent-child relationship.

Among parents whose attitudes were considered destructive the difficulties resulted more frequently from emotional reactions than from intellectual deficiencies. The two attitudes most frequently encountered were overanxiety and overprotectiveness. These elements were present in more than half of the cases, occasionally even when the general parental attitude was considered constructive.¹

Overstimulation of the patient to accomplish more than he was capable of was also noted frequently; in many cases this pointed to a strong

parental drive to see the patient compensate for his handicap, but it was unfortunate when parents chose sublimation on an intellectual level for children of dull or mediocre ability. In a few cases parents, disappointed in a handicapped child, turned for their own satisfaction to the physically normal siblings and discriminated against the afflicted one. Very rarely, a tendency to hide the handicapped child from outsiders was noted.

More was known about the attitudes of mothers than of fathers, and in this small series more constructive attitudes were noted among fathers than among mothers. Whether this difference is only apparent, because of the workers' more frequent contact with mothers and better knowledge of their feelings, or whether it is actual, is not clear. It is conceivable that since a handicapped child makes greater and more constant demands on the time and attention of the mother, her attitude could not be so detached as the father's.

Examination of the factors which entered into the building up of attitudes showed that those which produce constructive attitudes in parents of handicapped children are the same as those which make it possible for persons to meet crises of any sort, i. e., intellectual realization of the situation plus emotional acceptance and determination to take whatever steps are necessary or possible to alleviate it. As would be expected, these qualities are encountered most often in parents whose own emotional needs are satisfied and who have adequate emotional security. Because such parents often find excellent and ingenious ways of meeting the problems of a handicapped child with a minimum of outside assistance, it is to the less adequate group of parents that the attention and effort of medical-social workers is most frequently directed.

Ignorance of parents as to orthopedic conditions and the emotional needs of handicapped children appeared to be the most frequent cause of a destructive attitude. Parents seldom have first-hand experience with infantile paralysis or osteomyelitis until the catastrophe occurs in their own families. Some parents measure the experience of others by their own slight

¹ This apparent contradiction arose from the fact that it is impossible to determine accurately at what point anxiety is justified and where it becomes excessive. The social workers noted it wherever they felt the effect of the parental feeling was unfavorable for the child.

information and refuse to believe that anyone is able to help them. Others blindly rush from one charlatan to another, grasping at straws, and still others deposit the whole problem on the doorstep of an agency and proceed to wait for miracles.

Another frequent cause of destructive parental attitudes was immaturity or inadequacy of the parents. These parents would have difficulty assuming a true parental role under any circumstances, and they are much more unfit to grapple with the challenge that a handicapped child presents. Although emphatically not to be desired, this immaturity and dependency on the part of parents is not always without some good results for the child. If the parents turn to an agency where their own problems are understood and the workers are able and willing to assume parental roles with them, the real parents may be assisted to find courses of action which are beneficial for the child.

High on the list of causes of destructive attitudes was fear—fear of surgery, fear that the child might grow worse, fear that he could never be economically independent, fear of what others in the social group might think. This factor usually existed in conjunction with ignorance and sometimes yielded to the social worker's tools of explanation, reassurance, and interpretation. It was not surprising that cultural patterns played an important role in determining the attitudes of parents toward their handicapped children. In some cases the handicap was accepted stoically or philosophically as a divine visitation. These parents were often kind and indulgent toward the child, attempting to "make up" to him for his deprivations. Sometimes, however, the parents cheerfully overlooked the need of the handicapped child for special planning and expected him to fit himself into family life as well as he could, and find his own compensations or do without them.

Emotional instability was also important as a cause of destructive parental attitudes. This factor seldom was present alone, but existed most frequently with immaturity and inadequacy, and all three were seen more often in mothers than in fathers.

Economic considerations were found to be much less important than might be expected, perhaps because clinic service for accepted cases is not given or withheld on a financial basis. With care assured, apparently cost seldom entered into the actual parent-child relationship. Discouragement because of the length of the treatment program and former unpleasant medical or surgical experiences also played important roles in determining attitudes, especially attitudes toward treatment.

Undoubtedly there was a large element of guilt in many of the cases where overanxiety and overprotection were manifested. However, though the case workers frequently recognized some elements of guilt, they hesitated to analyze this feeling more fully without the assurance of psychiatric consultation. A few cases were carried under the supervision of a psychiatrist. There were many other cases in which the workers considered that this service would have been beneficial if it had been available in the community.

The series of cases was next examined to determine whether parental attitudes toward these handicapped children were subject to change. In 11 of the 51 cases there was not any indication of need for change, and in each of 14 additional cases there was 1 parent whose attitude was considered constructive. Thus in half the cases studied the child had at least 1 parent as a source of understanding and security in the home. There remained, however, 66 parents in whom workers were attempting to effect changes of attitude. This was felt to be completely accomplished with only 3 parents. Partial modification was brought about in the attitudes of 38, leaving 25 parents with unchanged attitudes. In only 6 cases was there total refusal of both parents to alter destructive attitudes.

The attitude of the parent toward treatment, although not to be confused with the parental attitude toward the child, is closely allied to it. Sometimes, though not always, one is an indication of the other.

In 42 cases parents acted jointly in matters of treatment. In only 1 case was a single parent able to block a major portion of the treatment plan. This reinforces the conviction of experi-

enced case workers, that if one parent can be won over to a course of action, he can safely be trusted to know the best way of persuading the other parent.

A few case examples bring out contrasts in parental attitudes. There is the approach of intelligent, well-adjusted parents whose only child was left at the age of 8 years with severe residual paralysis from poliomyelitis. They immediately set about bending all their efforts to making new plans and finding substitute means through which she could develop to her full mental and social capacity. They initiated the inquiry about treatment and meticulously followed out all the suggestions made by the doctor; at great personal sacrifice they allowed their daughter to spend long periods at a convalescent home. They persuaded her to accept willingly a transfer to a special public school for crippled children, over her natural resistance to a plan which took her away from a familiar parochial school where she had enjoyed considerable prestige. In order to be certain that she would continue to be included in the neighborhood group the other children were encouraged to make her yard their gathering place. Activities were discreetly and unobtrusively supervised, and several times wise parental intervention averted catastrophes. On one such occasion when a "show" offered no part for a slow-moving child on two crutches, the child was given the very satisfying job of directing and prompting the other "actors" from the wings. After a careful build-up over a 4-year period the parents made a special effort to purchase a piano in order to substitute an extra cultural advantage for some others which would inevitably be denied their child.

Another set of parents, who were foreign-born, faced the problem of a crippled boy of 4 years with very little intellectual appreciation of the implications for him. They trusted the medical aspect of it to an agency and followed treatment instructions without question. In the home their attitude of complete acceptance of the patient was so constructive from an emotional angle that they, and he, allowed his crippled condition to make very little difference in their lives. He was allowed to participate in all the neighborhood activities that he was able to share in and seemed to exercise his own judgment about ways and means of making a place for himself in spite of his handicap.

In both these cases the parental attitudes were in sharp contrast to that of the mother whose 14-year-old boy lost both hands in an explosion. She was an emotional person, thwarted in her marriage and concerned over her husband's alcoholism. She determined that her son must compensate for his loss by a legal career and was completely blind to the fact that his mental ability did not fit him to complete academic high-school subjects. She sought attention for him, demanding that he "show off" in spite of his own reluctance, and goaded him to an accomplishment which was impossible,

in order to satisfy her own need that he achieve recognition.

Very often the orthopedic problem may be only one of many—the ultimate calamity which forces families to seek help in situations where economic pressure, mental illness, marital strain have been present for years. In one instance a mother had been dissatisfied with her marriage for a long time and had been severely worried because of her husband's intermittent unemployment. When she learned that her 12-year-old daughter was developing a curvature of the spine she began to project a great deal of her anxiety about other things onto the child, weeping constantly and refusing to believe the doctor when he told her the condition could be treated so as to leave no permanent handicap. In this case it was possible to relieve enough of the other pressures, through the case-work process, to enable the mother to function fairly well as a constructive parent.

Occasionally there is an example of complete rejection of a handicapped child. In one case an immature father, who had been an athlete, turned against his only son who was so crippled as a result of infantile paralysis that he could never participate in any sport; he could never achieve recognition in the only field that his father considered important. The father lavished his affection on the younger daughter, who was a robust, active girl, and the patient withdrew more and more to the protection of his mother, indulging in crying spells, tantrums, and threats of suicide.

Rarely, a pathetic parent is encountered who attempts to shield a deformed child from all outside contacts. Even examination and treatment were denied to one 12-year-old girl who suffered from a severely progressive type of spinal curvature. It is difficult to be certain in some of these cases whether the parents' principal concern is for themselves or whether their behavior develops genuinely from excessive sensitiveness about the child's feeling in regard to his handicap.

Although individual cases vary too much to permit categorical classification of parental attitudes, all parent-child relationships may be considered from a twofold emotional and intellectual angle. If the attitudes of parents of the handicapped children chosen for this study were to be examined in this light, they might be grouped from top to bottom in four steps.

In the first group are those parents whose emotional acceptance of their handicapped child is complete, providing him always with a sense of security and preserving him from feelings of inferiority. The intellectual element is present to such a degree that both parents face the problem realistically, seek help, provide special

training, find recreational outlets, and wherever possible manipulate environment so that the effect of the handicap is counteracted.

Complete emotional acceptance of the child with his handicap is also seen in the second group of parents, but sometimes without their having full intellectual realization of the problems the child must face. Perhaps these parents seem unaffected by the handicap, and this philosophical point of view may often contribute something very desirable to the child's attitude toward his condition.

Among the third group of parents may be found adequate intellectual realization of the problem, but some unfavorable factor rising out of the emotional side of the picture is present. These parents may show an excess of anxiety, protectiveness, or ambition. There may be indifference or lack of real sympathy. It does not necessarily follow, however, that parents in this group neglect to seek medical care. Sometimes the most destructive attitudes drive them to the most meticulous observance of treatment suggestions.

The fourth group of parents is characterized principally by attitudes that are wholly destructive, such as extreme ignorance combined with stubborn unwillingness to be influenced, or rejection of a handicapped child who fails to live up to parental expectations. Fortunately, parents of these types were not often found.

A final glance at the results of this inquiry shows that the attitudes of parents of handi-

capped children are not different from the attitudes of parents of normal children, but that they are intensified.

The problems which a handicapped child presents bring to the surface many deep-seated feelings which might otherwise be suppressed, perhaps not even suspected. The physical handicap may precipitate expression of the parents' true feeling toward the child. For instance, parents may successfully cover up the fact that a child is unwanted until he becomes physically handicapped; then their feelings of guilt for not wanting him are stirred up to such an extent that they become oversolicitous or overprotective.

There is some inclination to accept the handicapped child on a level lower than his age. It is more common to restrict his horizons than to push him too hard. Physical handicaps seem to have less effect on parental attitudes in the lower social strata than in the more intelligent and privileged groups. In general, there were observed more destructive attitudes in mothers than in fathers. The attitudes of father and mother toward a child were different more often than they were identical, but parents were much more likely to share a constructive attitude than a destructive one.

Conclusions from a series of cases such as this provide some background against which case workers may compare their own experiences. It is hoped that they may be useful in bringing about a more understanding service to handicapped children.

BOOK NOTES

Public Health

Report on community health education Community Organization for Health Education is a report presented by the committee on community organization for health education of the American Public Health Association to the Public Health Education Section and the Health Officers Section (American Public Health Association, 1790 Broadway, New York, 1941. 120 pp. 9 cents).

In the introduction to the report Prof. C. E. Turner, chairman of the committee, says:

For some years now health education has been making a continually larger place for itself among the tools for promoting the public health. Experienced and professionally trained workers have developed excellent programs in schools, in health departments, and in private agencies. But the community is a unit, and it is natural that public-health workers should consider the development of a unified health-education program for the community as a whole.

The report describes experiences and experiments in community-health education in various parts of the country. Mr. Riley studied the functions assumed by

health departments, schools, and private agencies in correlated health-education programs in 14 States.

The report should prove of interest to agencies contemplating the development of health-education activities on a community basis.

Children's camps in Massachusetts.

Health and social aspects of children's summer camps, opportunities in nutrition for campers, camps for children with special problems, and the role of juvenile camps in national defense are covered in a camping number of *The Commonwealth*, quarterly bulletin of the Massachusetts Department of Public Health, Boston (Vol. 28, No. 1, Jan., Feb., Mar., 1941).

Standards for camp sanitation which are given in detail as prepared by the State Department of Public Health and adopted by 92 local boards of health apply to overnight camps and trailer camps as well as to recreational camps. Standards for health protection are outlined by Lendon Snedeker, M. D., chairman, Massachusetts Committee on Camps of the American Academy of Pediatrics.

The special camps described include: Tuberculosis camps, camps for diabetic children, camps for children with special problems, and the management of cardiac children at summer camps.

* * *

SCHOOL HEALTH SERVICES; A STUDY OF THE PROGRAM DEVELOPED BY THE HEALTH DEPARTMENT IN SIX TENNESSEE COUNTIES, by W. Frank Walker and Carolina R. Randolph. Commonwealth Fund, New York, 1941. 198 pp. \$1.50.

Analysis of approximately 58,000 records was involved in this Tennessee study, which seeks to answer some questions that health workers in schools and administrators planning school-health programs have long been asking.

Among the conclusions reached are the following:

1. Repeated examinations did not appear to increase the rate of corrections except in the case of visual defects.
2. The presence of a parent at the examination proved to be a more important factor in securing correction of defects than a nursing visit to the home following the examination.
3. Only 33 percent of dental defects, about 4 percent of throat defects, and 12 to 13 percent of visual defects were corrected following any examination.
4. The correction of visual, dental, and tonsil defects was higher among young children if a parent was present at the examination.
5. There was a significant drop in the incidence of dental, throat, and nutrition defects among 6-year-old children entering school in 1936 as compared with 1930.
6. Systematic attention to infants and pre-school children was seen to yield a return in terms of a lower incidence of dental and tonsil defects at the age of 6 years. No difference was

noted with regard to visual defects nor, interestingly enough, with regard to nutrition defects.

7. There is evidence of improvement in the health status of 12-year-old children between the years 1930 and 1936.

The final chapter is entitled, "What should the school health program be?" The authors here give constructive suggestions based on the results of the study.

J. M. B.

Nutrition

Nutrition Conference viewed by Survey Graphic

Under the general title, "Food for a Stronger America" the *Survey Graphic* for July 1941 (Vol. 30, No. 7) contains a special section on the National Nutrition Conference for Defense, held in Washington in May. The statements of the conference speakers, pointed up with photographs, form a composite picture of a nation "faced with a serious problem of nutrition," where a great many of the people are not receiving the food they need for strength of mind and body, but where the gravity of the situation is mitigated by "the hopeful and challenging fact that we now have the scientific knowledge, the means, and the national will to do something about it."

* * *

A TEXTBOOK OF DIETETICS, by L. S. P. Davidson and Ian A. Anderson. Paul B. Hoeber, New York, 1941. 324 pp. \$4.25.

The two Scottish authors of this book, both physicians who, according to Sir John Boyd Orr's foreword, have done original research on nutrition in relation to health and disease, have produced an original text based on lectures given to medical students at the University of Aberdeen.

The book attempts to equip the general practitioner to give sound advice on the relation of diet to the maintenance of health and to undertake with confidence the dietetic treatment of disease. To that end the customary sections on diet in health and disease are preceded by a brief general survey of the Nation's diet and a concise "but for clinical purposes complete account of the physiology of nutrition." Economic considerations are never lost sight of; for each disease there are given two samples of daily diets, one of which is for the patient with a very limited income.

The sections on therapeutic diets carry out the authors' conviction that the scientific principles underlying all dietary recommendations must be stated since "no dietetic restrictions should be imposed that cannot be justified on biochemical, physiological, or clinical grounds." Moreover, the dietetic treatment of each disease is considered in relation to the associated therapy and hygiene so that dietetics appears in true perspective as a therapeutic measure.

To treat nutrition and dietetics so broadly in a book of modest size has necessitated careful selection of facts that are both well-established and of practical importance.

DETERMINATION OF NUTRITIONAL STATUS, by E. W. McHenry. *Canadian Public Health Journal*, Vol. 32, No. 5 (May 1941), pp. 231-235.

A DIETARY SURVEY IN HALIFAX, by E. Gordon Young. *Ibid.*, pp. 236-240.

ENQUÊTE SUR L'ALIMENTATION HABITUELLE DES FAMILLES DE PETITS-SALARIÉS DANS LA VILLE DE QUÉBEC, by J. Ernest Sylvestre and Honoré Nadeau. *Ibid.*, pp. 241-250.

A DIETARY INVESTIGATION IN TORONTO FAMILIES HAVING ANNUAL INCOMES BETWEEN \$1,500 AND \$2,400. *Ibid.*, pp. 251-258.

A DIETARY SURVEY IN EDMONTON, by George Hunter and L. Bradley Pett. *Ibid.*, pp. 259-265.

NUTRITION IN CANADA; AN EDITORIAL. *Ibid.*, pp. 268-269.

The Canadian Council of Nutrition, organized in 1938, has formulated dietary standards for the country, has compiled tables of composition of Canadian foods, and has carried out large-scale studies of food consumption of individual members of low-income families in each of four principal cities: Halifax, Quebec, Toronto, and Edmonton. The dietary standards are set forth and the findings of each of the dietary studies are reported in the May 1941 issue of the *Canadian Public Health Journal*, which is devoted almost entirely to nutrition.

The outstanding findings, as reviewed in an editorial, are that the food supplies of low-income families are not satisfactory and that mothers are the least well-fed members of family groups. There is a shortage of protective foods, resulting in deficiencies in intake of calcium particularly for children, of the B vitamins for all individuals, and of iron for women and children. Some families are not spending enough for food to purchase an adequate diet, but there are

a sufficient number who could obtain enough of the right kinds of food for the money that they are now spending to point the urgent need for a comprehensive program of nutritional education.

THE INFLUENCE OF NUTRITIONAL EDUCATION IN FAMILIES OF THE MULBERRY AREA OF NEW YORK CITY, by Dorothy L. Bovee and Jean Downes. *Milbank Memorial Fund Quarterly*, Vol. 19, No. 2 (April 1941), pp. 121-146. 20 cents.

Between July 1937 and December 1939 the nurses and the nutritionist of the Mulberry Health Center carried out a special study to find out whether intensive instruction in nutrition in the home will bring about improvement in children's habits of eating and other practices related to nutrition. The food and health habits of the children in 135 families were rated at the beginning of the study and again after 9 months. In 90 families a special program in nutrition education was carried on; in half of these families the instruction was done by the public-health nurses with the advice of the nutritionist; in half, the nutritionist did the teaching herself. The remaining 45 families served as a control group.

In the families in which special educational work was done, there was a marked increase in the use of milk, eggs, fruits and tomatoes, and vegetables. There was relatively little change in the habits of the children of the control families. The children in the nutritionist's group showed greater improvement than did the children in the nurses' group of families. It should be pointed out, however, that the nutritionist was able to devote all her time in the homes to nutrition teaching, whereas the nurses included nutrition teaching in a program of general health supervision. In none of the groups was marked improvement noted in hours of sleep and bedtime-habits, which were determined to a considerable extent by the crowded conditions under which all the families lived.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Pending Bill for Federal Aid for Education

The current bill to provide Federal aid to education takes into consideration emergency needs growing out of the defense situation. Senator Thomas on April 7, 1941, introduced the present bill (S. 1313) known as the Educational Finance Act of 1941 "To strengthen the national defense and promote the general welfare through the appropriation of funds to assist the States and Territories in meeting financial emergencies in education and in reducing inequalities of educational opportunities." Hearings on the bill were held before a subcommittee of the Senate Committee on Education and Labor, April 28-30.

The bill would provide an appropriation of \$300,000,000 of Federal funds each year to help the States provide additional school facilities for children of workers in centers of defense industry and to equalize educational opportunities within States and among the States, especially for children in rural areas, children living on Federal reservations, and children of

migratory workers. The bill specifically provides for the continuance of State and local responsibility for the administration of the schools.

Incorporated in the bill is an interesting section on findings of fact, including (1) public elementary and secondary schools throughout the Nation for all children are essential to a national program of total defense; (2) State and local school jurisdictions in many cases are not able to provide adequate educational opportunities in areas adjacent to defense activities and industries; (3) millions of children, especially those in rural areas, those residing on Federal properties, and the children of migratory workers, are in school districts in which the school facilities are wholly inadequate; (4) the States are unable to reduce substantially the inequalities of educational opportunities, because of differences in tax-paying ability in relation to the number of children of school age.

BOOK NOTES

SUMMARY OF YOUTH EMPLOYMENT ENQUIRY, APRIL 1941.

Canadian Welfare Council, Ottawa, Canada. 19 pp. Mimeographed.

This statement summarizes replies to inquiries sent to child-welfare agencies and to a few private individuals in Canada to find out whether employment under present conditions is attracting an increasing number of school children.

No heavy increase was reported from any area in the number of boys and girls of compulsory-school-attendance age who were dropping out of school. A fairly steady increase (about 10 percent) was found in the number of work permits issued to minors.

The comment is made that:

Difficulties facing youth today have not reached a sharply acute form for the general community in relation to employment. But the shadow of the wastage of the last 10 years has not lifted. With that experience in mind, everything possible under present-day conditions should be done to safeguard youth against the heartbreaking experiences of the last decade, to assure them decent home standards, reasonable wage levels and working conditions, skilled vocational training, and the best in vocational guidance and placement facilities. It is reasonable to press for these things. They are sane, and their sanity will increase the effectiveness and resource of youth for the simple reason that they broaden the outlook of the individual personality.

Children's Bureau News

Several important changes in the staff of the United States Children's Bureau during recent months have been announced by its Chief, Katharine F. Lenroot.

Martha M. Eliot, M. D., Assistant Chief of the Bureau since 1934, became Associate Chief in May 1941. She continues to collaborate with the Chief in developing and carrying out policies governing the entire field of the Bureau's work and to have special responsibility for the health work of the Bureau.

Charles I. Schottland was appointed in May as Assistant to the Chief of the Bureau. Mr. Schottland is a graduate of the University of California at Los Angeles, has had postgraduate training in social work and law, and is a member of the bar of the State of California. In recent years he has served as State Relief Administrator, Deputy Director of the Department of Social Welfare, and Executive Director of the Federation of Jewish Welfare Organizations of Los Angeles. Mr. Schottland will assist the Chief and the Associate Chief in developing policies governing the administration of the Children's Bureau and will have special responsibility for the Bureau's activities in the general field of social service.

These administrative changes do not affect the Industrial Division, whose Director, Beatrice McConnell, continues to report to the Chief of the Bureau on all matters relating to child labor and the employment problems of youth.

The Maternal and Child Health Division and the Crippled Children's Division have been combined as the Division of Health Services, with Edwin F. Daily, M. D., formerly Director of the Maternal and Child Health Division, as Director of the new division. Hart E. Van Riper, M. D., formerly Assistant Director of the Maternal and Child Health Division, is Assistant Director for Maternal and Child

Health; and A. L. Van Horn, M. D., formerly Assistant Director of the Crippled Children's Division, is Assistant Director for Crippled Children.

Dr. Robert C. Hood, formerly Director of the Crippled Children's Division, resigned from the Children's Bureau in June and is now Director of the Maternal and Child Health Division, Florida State Board of Health.

Jacob Yerushahay, Ph. D., was appointed in January as Director of the Division of Statistical Research. He succeeded Robert J. Myers, Ph. D., who left the Bureau to become head of the Division of Wage and Hour Statistics of the Bureau of Labor Statistics. Dr. Yerushahay received his doctor's degree at Johns Hopkins University in 1930. He has conducted research with the National Research Council at the University of Illinois and at Princeton University and has been instructor in mathematics at Johns Hopkins University, statistician in the New York State Department of Health, and statistician in the Division of Public Health Methods of the National Institute of Health, United States Public Health Service.

Katherine Bain, M. D., was appointed in September 1940 as Director of the Division of Research in Child Development. Dr. Bain has been instructor in clinical pediatrics at Washington University School of Medicine in St. Louis, Mo., and has done research work in the field of allergy, particularly in relation to infant feeding. Dr. Bain is in charge of health studies of the Bureau.

Ethel C. Dunham, M. D., formerly Director of the Division of Research in Child Development, continues to give consultation service on problems of premature and newborn infants and is devoting herself to special studies on the care of premature infants.

Administrative officials of the Children's Bureau include the following persons:

Chief.—

Katharine F. Lenroot.

Associate Chief.—

Martha M. Eliot.

Assistant to the Chief.—

Charles I. Schottland.

Industrial Division.—

Beatrice McConnell, Director.

Elizabeth S. Johnson, Assistant Director in Charge of Research.

Elizabeth B. Coleman, Assistant Director in Charge of Child Labor Administration.

Division of Health Services.—

Edwin F. Daily, Director.

Hart E. Van Riper, Assistant Director for Maternal and Child Health.

A. L. Van Horn, Assistant Director for Crippled Children.

Naomi Deutsch, Director of Public Health Nursing Unit.

Edith M. Baker, Director of Medical Social Work Unit.

Child Welfare Division.—

Mary Irene Atkinson, Director.

Child Guidance Division.—

Elsa Castendyck, Director.

Division of Research in Child Development.—

Katherine M. Bain, Director.

Social Service Division.—

Agnes K. Hanna, Director.

Division of Statistical Research.—

Jacob Yerushalmy, Director.

Editorial Division.—

Isabelle M. Hopkins, Director.

Administrative Section.—

Laura Elmore Warren, Administrative Assistant to the Chief.

State Audits Unit.—

William J. Maguire, Administrative Officer.

Merit System Unit.—

Ruth O. Blakeslee, Consultant in Maternal and Child Welfare Services.

Central Files Section.—

Ella O. Latham, Head.

Mail, Correspondence, and Stenographic Section.—

Anna T. McNulty, Head.

DEFENSE ACTIVITIES

The Chief of the Bureau was appointed in January 1941 as Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities, Paul V. McNutt.

The Bureau is represented on the interdepartmental council and on several of the committees that advise the Coordinator in the

development of programs. Regional consultants of the Bureau serve similarly on regional advisory councils organized by the Coordinator's Office. Through its representation on the Advisory Committee on Nutrition the Children's Bureau participated actively in the organization and conduct of the National Nutrition Conference for Defense held in Washington May 26-28, 1941.

Mr. McNutt also requested the assignment of a staff member of the Children's Bureau to serve in the Coordinator's Office as liaison officer in matters relating to children. Charles I. Schottland, Assistant to the Chief, has been assigned to serve in this capacity.

At the request of F. H. LaGuardia, Director of Civilian Defense, the Associate Chief of the Children's Bureau was appointed in August 1941 as liaison officer from the Children's Bureau to assist his office in the development of a child-welfare program in connection with civilian defense.

The letters of the Coordinator of Health, Welfare, and Related Defense Activities and the Director of Civilian Defense to Miss Lenroot follow:

From the Coordinator of Health, Welfare, and Related Defense Activities:

I am writing to inquire whether you, as Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities, will be responsible through the Children's Bureau, for assisting me in formulating and executing plans, policies, and programs designed to assure the protection of children during the national-defense emergency. This work, of course, will be carried on in cooperation with the advisory committees functioning under the Program Planning Branch of this office, and with other agencies of the Federal Government and non-governmental agencies concerned with the health and welfare of children.

Although the well-being of children is closely related to the health of the general population, the security of family life, and provision for nutrition, recreation and legal and social protection, children present special problems which must be considered in reference to all aspects of their welfare. Adequate consideration must be given to such subjects as the following: Provision for the infant and preschool child in families where the mother is employed in an occupation related to national defense; protection of the health and welfare of children in military or industrial defense communities; planning wholesome

recreation for children in such communities; maintaining and enforcing child-labor standards; preparing plans and material for training volunteers to serve in child-health and child-welfare agencies or in child-care centers; anticipating needs for additional trained personnel for child-health and child-welfare work.

These subjects need to be considered with reference to:

- (a) Special needs of children in military and industrial defense areas;
- (b) Advance planning for evacuation of children under conditions of grave emergency;
- (c) Measures essential for safeguarding the health and well-being of children throughout the country.

The Children's Bureau being the agency in the Federal Government charged with special responsibility for child welfare, is the appropriate agency to develop for the Coordinator's Office comprehensive plans for assuring proper safeguards to children, whose health and well-being are of primary importance in the program of national defense. Many aspects of child welfare do not fall within the scope of any of the present advisory committees, and all phases of health

and welfare under the defense program need to be reviewed to make sure that they are properly coordinated in relation to child welfare, and that adequate emphasis is given to the protection of children. When general policies and plans have been developed, they can be translated into action with the assistance of Regional Advisory Councils and cooperating State and local agencies.

In order that close cooperation with other services in the Office of the Coordinator may be maintained, I suggest that you assign a member of the staff of the Children's Bureau to serve in my office as liaison officer in matters relating to children.

From the Director of Civilian Defense:

In connection with the work now under way in the development of plans for evacuation, and its relation to children's welfare, I find that it will be most desirable to have a liaison officer from your Department to assist in this office in the preparation of a program as far as child welfare is concerned.

Owing to the broad background of Dr. Martha M. Eliot in this particular branch of the subject, I am requesting that she be appointed as the liaison officer from your Bureau to assist our office in this work.

Civilian Defense Program

The United States Office of Civilian Defense in Washington, D. C., has issued over the signature of F. H. LaGuardia, Director, a bulletin entitled *Local Organization for Civilian Defense*. This contains a suggested civil-defense ordinance and chart of organization made to fit the needs of the average city in the United States. This plan can be adapted to city, county, and other political subdivisions.

It is stated that other bulletins will be issued at intervals and that the Regional Offices of Civilian Defense will furnish advice and assistance in solving local problems.

National Citizens Committee Appoints Director

The appointment of Mrs. Betty Eckhardt May as Director of the National Citizens Committee of the White House Conference on Children in a Democracy was announced as of August 16. Mrs. May has had extensive field experience in community organization, youth leadership, and adult education. She takes the place of H. Ida Curry, who had retired from active service with the New York State Charities Aid Association in 1938 but consented to assist the National Citizens Committee to organize its work last year.

The office of the committee will be at 122 East Twenty-second Street, New York.

Institute on World Organization

An institute organized by a small committee as the first step toward establishing a permanent center for the study and dissemination of the principles and method of world organization will be held in Washington, D. C., September 2-13. The American University has offered the facilities of its campus for the use of the institute.

A study will be made of the first comprehensive experiments in world government—the League of Nations, the International Labor Organization, and the Permanent Court of

International Justice. The subjects discussed will include the work of the so-called technical organizations, such as economics and finance, communications and transit, health, social questions, intellectual cooperation, nutrition, and narcotics control. Lecturers are, for the most part, experts who have been closely associated for years with the work of the League. Ten nationalities will be represented. Arrangements have been made for publication of the lectures.

Application for membership in the institute should be made to the Committee Headquarters, 1907 F Street NW., Washington, D. C. The registration fee is \$5.

Symposia at University of Chicago

A 5-day series of symposia will be held at the University of Chicago beginning September 22 in connection with the celebration of the University's fiftieth anniversary. The symposia will deal with the newest fundamental advances in the biological, physical, and social sciences, the humanities, law, business, religion, and social service, in keeping with the theme of the university's celebration—New Frontiers in Education and Research.

Thirty-nine universities, including 6 in foreign nations, and 15 museums, research organizations, and Government agencies will be represented in the symposia.

Second American Congress on Obstetrics and Gynecology

The Second American Congress on Obstetrics and Gynecology will be held in St. Louis, Mo., April 6-10, 1942.

The general plan for the program will be much the same as that of the first Congress, which was held in Cleveland in September 1939. There will be sectional meetings for the various groups—physicians, nurses, public-health workers, administrators, and educators—and general sessions for all members. Some of the evening sessions will be open to the public. Various committees have already been set up.

Dr. Fred L. Adair, chairman of the American Committee on Maternal Welfare, Chicago, is the chairman of the executive committee of the Congress.

The program committee, with Dr. E. D. Plass as chairman and Dr. William F. Mengert as secretary, is working with the following subcommittee chairmen: Dr. Ralph A. Reis, for the Medical Section; Georgia Hukill, for the Nursing Section; Dr. R. C. Buerki, for the

Hospital Section; Dr. Edwin F. Daily, for the Public-Health Section; and Dr. Clair Folsome, for the Educators Section.

Dr. Robert L. DeNormandie is chairman of the committee on public meetings.

The committee on scientific and educational exhibits is headed by Dr. H. C. Heseltine, with Dr. Charles Galloway as secretary.

Dr. Buford Hamilton, chairman of the membership committee, has organized a central committee representing each of the five groups interested in the Congress. State membership committees are being formed in all the States. There are also committees for special organizations.

Dr. Joseph A. Baer is serving as chairman of the committee on lay publicity.

Dr. George W. Kosmak heads the committee in charge of professional publicity for the various sections.

Dr. William C. Danforth is chairman of the budget and finance committee and Dr. Goodrich C. Schauffler, of the publication committee.

Oct. 27-Nov.— International Labor Conference, New York.
General sessions open to the public.

CONFERENCE CALENDAR

- Sept. 29-
Oct. 3 National Recreation Association. Twenty-sixth National Recreation Congress, Baltimore, Md. Information: National Recreation Association, 315 Fourth Avenue, New York.
- Oct. 4-8 National Society for Crippled Children of the United States of America. Twentieth annual convention, Louisville, Ky. Permanent headquarters: Elyria, Ohio.
- Oct. 6-10 National Safety Council. Thirtieth National Safety Congress and Exposition, Chicago, Ill.
- Oct. 9-11 American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill.
- Oct. 14-17 American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York.
- Oct. 20-24 American Dietetic Association. Twenty-fourth annual meeting, St. Louis, Mo. Information: American Dietetic Association, 185 North Wabash Avenue, Chicago, Ill.
- Oct. 27-31 American Dental Association. Eighty-third meeting, Houston, Tex. Permanent headquarters: Chicago, Ill.
- Nov. 11-14 Southern Medical Association. Thirty-fifth annual meeting, St. Louis, Mo. Permanent headquarters: Birmingham, Ala.
- Nov. 14-15 Child Study Association of America. Two-day institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.
- Dec. 4-6 National Society for Prevention of Blindness. Annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

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the

CHILD

*** Monthly Bulletin ***



MARYLAND HEALTH TRAILER

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

SEPTEMBER 1941

MARYLAND HEALTH TRAILER

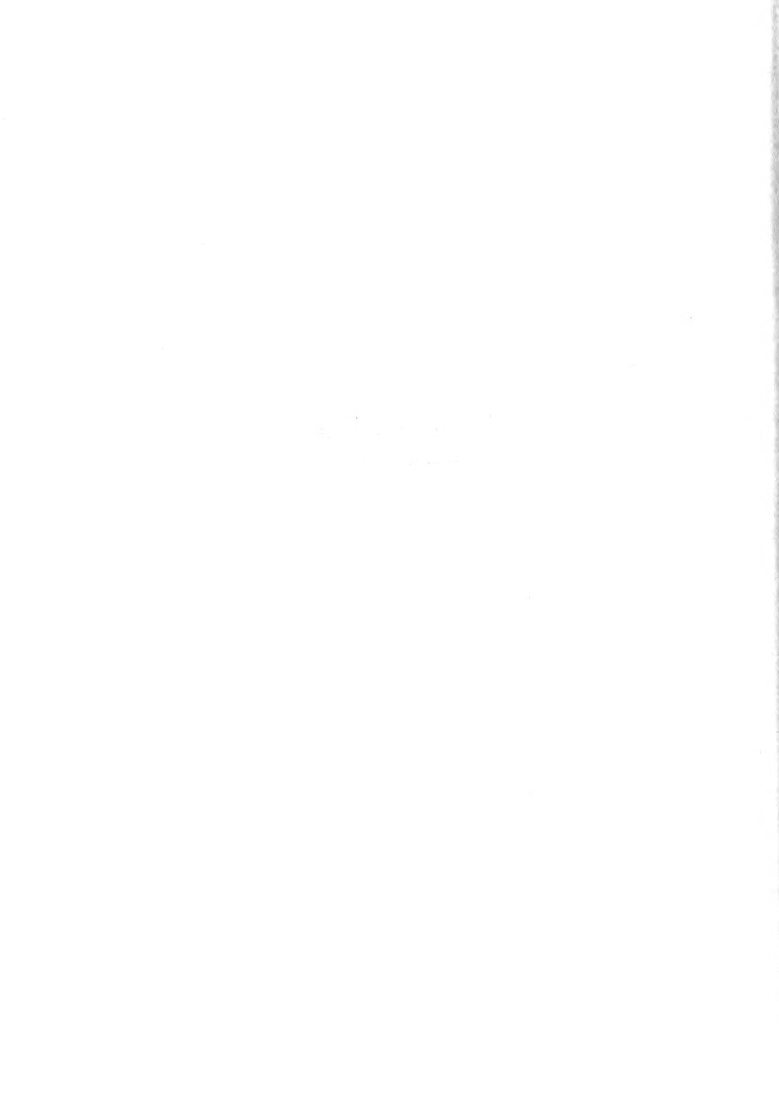
Medical and nursing care is brought to mothers and children in rural areas of Maryland through the health trailer, operated by the Bureau of Child Hygiene of the Maryland State Department of Health. The health trailer is equipped as an examination room. The photograph on the cover shows the physician giving a complete physical examination to the young infant of a mother who has reported for postnatal care.



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.



• **BIRTH** •

• **GROWTH** •

• **CHILD HEALTH** •

Obstetric Care in Rural Areas

Based on a Study of 1,523 Births in Maryland

BY J. H. MASON KNOX, JR., M. D., CHARLES H. PECKHAM, M. D., AND MYRON E. WEGMAN, M. D.,
*Bureau of Child Hygiene, Maryland State Department of Health, Baltimore, Md.*¹

MANY studies of maternal deaths have been made. They have served a useful purpose because they have indicated that by different treatment before or after delivery many deaths might be prevented. They have not, however, afforded information on the care received by mothers who survived and consequently have given no body of fact with respect to the adequacy of community facilities for protection of the mother or child.

By investigating the care received by all mothers whose children are born and registered as either live births or stillbirths over a period of time, it is possible to ascertain the deficiencies in the maternity services of any area that is studied and to obtain a basis on which to formulate plans for furnishing the additional services that are needed. Such studies are especially urgent in rural areas because women who live in such areas bear more than half of the Nation's children (57 percent of the live births in the United States in 1938 were births to mothers who lived in rural areas) and because facilities for care in rural

areas are well known to be less adequate than facilities for care in cities.

This study is an attempt to ascertain the general situation with respect to maternal care in the rural areas of Maryland by means of studying consecutive births (live births and stillbirths) to mothers in representative counties of the State. It is based on information for 1,523 women (1,011 white, 512 Negro) who lived in these four counties and who had children born in 1937 or 1938 whose births were registered.

The four counties were: (1) Allegany County, which is located in the western, mountainous part of the State and which has Cumberland as its county seat; (2) Anne Arundel County, which is located on the Chesapeake Bay tide-water section and which includes Annapolis, the capital of the State and the site of the United States Naval Academy; (3) Montgomery County, which has no city of as many as 10,000 population but which adjoins the District of Columbia and has a considerable suburban population; and (4) Wicomico County, which is an Eastern Shore county with several textile factories in its principal city (Salisbury) and which is given over to vegetable and fruit raising in its rural sections.

¹ Dr. Knox is Chief of the Bureau of Child Hygiene, Maryland State Department of Health, Baltimore, Md. Dr. Peckham was formerly Obstetrical Consultant and Dr. Wegman, Pediatric Consultant of the Bureau of Child Hygiene.

The 1940 census shows that the four counties had a total population of 273,790 and that about three-fourths of the population lived in rural areas, that is, on farms and in towns and cities of less than 10,000 population. Figures from the State Department of Health show that the average annual number of live births to mothers who were residents of these four counties during the 3-year period 1936-38 was 4,652 (3,921 white, 731 Negro). They also show that almost nine-tenths (89.2 percent) of all live births to such mothers (96.2 percent of the white; 51.4 percent of the Negro) were attended by physicians; only about one-tenth (10.8 percent) were attended by nonmedical persons (3.8 percent of the white women, 48.6 percent of the Negro). The nonmedical persons were mainly midwives (table 1).

The health situation of mothers and babies in these four counties was slightly better than in all Maryland counties. The maternal mortality rate in the four counties was 38.7 deaths per 10,000 live births compared with 44.4 in all Maryland counties during the period 1936-38; the infant mortality rate was 61.6 deaths per 1,000 live births compared with 64.7 in all counties; and the stillbirth rate was 41.5 stillbirths per 1,000 live births compared with 46.1 for all counties (table 2).

The mortality rates for white mothers and babies in the four counties, as would be expected, were lower than those for the Negroes. The maternal mortality rate for white women (33.2) was less than half the rate for Negro women (68.4) during the period 1936-38; in like manner, the mortality rate for white infants (51.8) was less than half the rate (114.4) for Negro infants. The stillbirth rate was 36.5 per 1,000 live births for the white population, compared with 68.4 for the Negro (table 2).

All the four counties have organized health departments with full-time health officers. In each of the counties prenatal clinics for the low-income group are conducted, chiefly by local physicians, under the auspices of the State Department of Health. These clinics are visited at regular intervals by the obstetric consultant of the Bureau of Child Hygiene. At the time of the survey no provision was made for de-

TABLE 1.—Average annual number of live births to resident mothers by race and attendant at birth in all Maryland counties and in the 4 counties that were studied; 1936-38

Area and race	Total	Physician		Nonmedical attendant	
		Num-ber	Per-cent	Num-ber	Per-cent
All counties ¹	16, 507	14, 392	87. 2	2, 115	12. 8
4 counties.....	4, 652	4, 148	89. 2	504	10. 8
Allegany.....	1, 709	1, 692	99. 0	17	1. 0
Anne Arundel.....	1, 148	830	72. 3	318	27. 7
Montgomery.....	1, 294	1, 249	96. 5	45	3. 5
Wicomico.....	501	377	75. 2	124	24. 8
WHITE					
All counties ¹	13, 466	12, 821	95. 2	645	4. 8
4 counties.....	3, 921	3, 772	96. 2	149	3. 8
Allegany.....	1, 686	1, 669	99. 0	17	1. 0
Anne Arundel.....	757	690	91. 1	67	8. 9
Montgomery.....	1, 115	1, 106	99. 2	9	. 8
Wicomico.....	363	307	84. 6	56	15. 4
NEGRO					
All counties ¹	3, 041	1, 571	51. 7	1, 470	48. 3
4 counties.....	731	376	51. 4	355	48. 6
Allegany.....	23	23	100. 0	-----	-----
Anne Arundel.....	391	140	35. 8	251	64. 2
Montgomery.....	179	143	79. 9	36	20. 1
Wicomico.....	138	70	50. 7	68	49. 3

¹ Comprises the State of Maryland exclusive of Baltimore city.

Based on data from Annual Reports of the State Board of Health of Maryland.

livery service through the clinics except in cases where abnormal conditions existed.

Method of Conducting Study.

During the period of survey—1 year in Anne Arundel County, which supplied two-thirds of the material, and shorter periods in the other counties—every birth was investigated. As soon as the birth certificate was received in the county health office the public-health nurse of the district where the mother lived visited the

TABLE 2.—*Maternal and infant mortality and stillbirth rates by race for residents of all counties of Maryland and the 4 counties that were studied; 1936-38*

Area and race	Maternal mortality rate ¹	Infant mortality rate ²	Stillbirth rate ³
All counties ²	44.4	64.7	46.1
4 counties	38.7	61.6	41.5
Allegany	35.1	60.5	48.8
Anne Arundel	46.5	78.1	45.9
Montgomery	25.8	45.3	28.3
Wicomico	66.6	69.9	40.6
WHITE			
All counties ³	36.4	52.8	38.5
4 counties	33.2	51.8	36.5
Allegany	35.6	59.7	48.2
Anne Arundel	30.8	52.9	30.8
Montgomery	23.9	36.8	23.6
Wicomico	55.1	58.8	33.1
NEGRO			
All counties ³	80.0	117.6	79.7
4 counties	68.4	114.4	68.4
Allegany	-----	114.3	85.7
Anne Arundel	76.7	127.0	75.0
Montgomery	37.2	98.7	57.7
Wicomico	96.6	99.0	60.4

¹ Deaths per 10,000 live births.

² Deaths per 1,000 live births.

³ Comprises the State of Maryland exclusive of Baltimore city.

Based on data from Annual Reports of the State Board of Health of Maryland.

home and filled out a survey form. The number of women whose histories were investigated in each county was:

County	Total	White	Negro
Total	1,523	1,011	512
Allegany	221	219	2
Anne Arundel	972	557	415
Montgomery	110	84	26
Wicomico	220	151	69

The nurse usually obtained the information for the survey form from the mother (90.6

percent); for 3.9 percent of the forms it was obtained from relatives, for 2.6 percent from the physician, and for 2.9 percent from other sources and sources not stated.

The form comprised some 60 items, which related mainly to previous child-bearing history, the complications of pregnancy and labor, the details of prenatal and delivery care, and the results of the pregnancy to the mother and child. Information was not supplied on every schedule form for every item. The informant was not always able to supply full information. Some nurses were able to secure more complete information than other nurses. Certain items of the form were found to be lacking in specificity. For the most basic information, however, the facts were usually obtained and carefully filled in.

The findings presented here are particularly those relating to prenatal and delivery care. They are expressed, therefore, in percentages of the totals for which answers were given, that is, they are based on the total number of women for whom the answers were known. For none of the items discussed was the unknown group sufficiently large to affect the significance of the finding.

The schedule count by race shows that one-third (512) of the 1,523 women included in the study were Negroes; this is a larger proportion than that shown for births in the four counties in the period 1936-38. The weighting, per se, however, does not affect the findings for the study because they are presented separately for the two racial groups.

Prenatal Care.

Prenatal care had been received by nine-tenths of the white and four-fifths of the Negro women included in the study. One-tenth of the white and one-fifth of the Negro women had had no care. Information as to whether prenatal care was received was obtained for every woman included in the study.

Prenatal care	Percent of women	Number of women
	White	Negro
Prenatal care	90.1	78.1
No prenatal care	9.9	21.9
	911	400
	100	112

There is every reason to believe that prenatal care is more common today than in earlier years.

Nevertheless, it is obvious that there is plenty of room for further progress.

Most of the women who received prenatal care received it from physicians. White women usually obtained this care from private physicians; 78 percent received care solely from private physicians, compared with 31 percent of the Negro women. Half of the Negro women and 11 percent of the white women received care solely from clinics. Some women of each racial group (8 percent of the white, 12 percent of the Negro) received care from both private physicians and clinics; this percentage is explained partly by the fact that some physicians made a practice of referring to clinics for prenatal care the women of low income to whom they expected to give care at delivery.

Source of prenatal care	Percent of women		Number of women	
	White	Negro	White	Negro
Total women reporting care -----	100.0	100.0	911	400
Physician -----	97.6	92.8	889	371
Private physician -----	78.2	30.5	712	122
Clinic physician -----	11.3	50.0	103	200
Private and clinic physician -----	8.1	12.3	74	49
Public-health nurse (no physician) -----	2.4	7.2	22	29

A few women of both races who for one reason or another could not be brought in contact with physicians received prenatal care solely from public-health nurses. For these women the nurses, in addition to their regular work of giving health supervision and instruction through home visits, made blood-pressure readings and took samples of urine for analysis.

The public-health nurses made home visits to more than one-fifth of all the white and more than half of all the Negro women who received medical prenatal care. As would be expected, the nurses more often visited women who were clinic cases than women who were cases solely of private physicians. They visited 45 percent of the white and 75 percent of the Negro women who received care from clinics as compared with 16 percent of the white and 17 percent of the Negro women who received care solely from private physicians.

Adequacy of care.—Merely to supply prenatal care is only one step in the problem of

the mother's care. The quality of the care is the important feature. If the prenatal care provided is to be adequate, it is of first importance not only that expectant mothers seek care from the physician early in pregnancy and remain under his supervision throughout the period, but also that the care given by the physician include certain types of examinations, tests, and treatment.

As a large proportion of the women included in the present study lived in rural areas where family incomes were low and few physicians appreciated the need of mothers for careful supervision throughout pregnancy, it was found necessary in determining adequate prenatal care for purposes of this study to select minimum criteria which would be met by a fair proportion of the women. These minimum criteria of adequate care were:

1. First visit for prenatal care not later than the sixth month of pregnancy.
2. At least three prenatal visits to physician or clinic.
3. Last visit not more than 5 weeks before delivery.
4. Prenatal physical examination, measurement of pelvis, blood-pressure determination, and urine analysis.

After prenatal care was graded by these minimum criteria, it was found that only 44 percent of the 911 white women and 28 percent of the 400 Negro women who received prenatal care had care of the quality termed adequate; and that 56 percent of the white and 72 percent of the Negro women had had care classified as inadequate even by these minimum criteria.

Month of pregnancy when prenatal care began.—Care was begun before the end of the second trimester of pregnancy by almost four-fifths of the white women studied and by almost

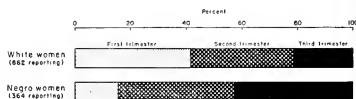


Chart 1.—Period of pregnancy in which care was begun, women who received prenatal care in four Maryland counties, 1938.

three-fifths of the Negro women. Only about one-fifth of the white women, compared with

two-fifths of the Negro women, began their prenatal care in the last trimester.

Number of visits for prenatal care.—As the number of visits for prenatal care depends in part at least upon the month of pregnancy when care begins, it is not surprising to find that a larger proportion of Negro than of white women made few visits for care. At least three visits is one of the minimum criteria for adequate care used in this study. Less than three visits were made by 56 percent of the Negro women who received care from private physicians and 52 percent of the Negro women who attended clinics. In sharp contrast, only 20 percent of the white women who received care from private physicians and only 38 percent of the white women who attended clinics made less than three visits.

Obstetricians expect an average of 10 to 12 visits in a routine, normal pregnancy. A little more than one-fifth of the white women who received care from private physicians made 10 or more visits; for each of the other groups of women the proportion was less than 10 percent.

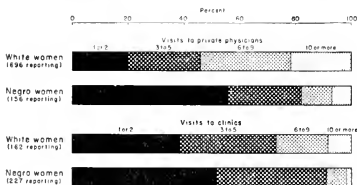


Chart 2.—Visits made to private physicians and to clinics for care, women who received prenatal care in four Maryland counties, 1938.

The marked difference between the number of visits made by white women and by Negro women is explained partly by the fact that a large number of physicians refer to clinics for prenatal care the women of low-income classes whom they expect to deliver. Also, the standard practice among many practitioners is to make an extra charge for each prenatal visit, because they have not yet come to consider such visits an essential part of obstetric care. In the low-income clinic group, work at home, difficulty in securing transportation to the few

clinic centers available, and lack of appreciation of the importance of regular attendance help to explain the small number of visits.

Interval between last prenatal visit and delivery.—Almost all the women who received prenatal care had made a visit for prenatal care shortly before delivery; 92 percent of the white and 85 percent of the Negro women who received prenatal care had made a prenatal visit less than 40 days before their delivery occurred. It is a well-known fact that many women who do not seek prenatal care early in pregnancy visit a physician or a clinic in the last month in order to arrange for delivery care. The proportions just cited, of course, include women who made first visits at this time as well as women who began their care at earlier periods and made a last prenatal visit at this time.

Physical examination, pelvic measurement, blood pressure, and urinalysis.—For almost all of the 911 white and 400 Negro women who received prenatal care information was obtained as to whether physical examination had been made, pelvis measured, blood pressure taken, and urine analyzed. The percentage of completeness of reporting was lowest for pelvic measurements, but information as to whether measurements were taken was obtained for 95 percent of the white and 94 percent of the Negro women who had received care. Findings on these aspects of care are consequently presented in terms of percentages based on total women for whom the information was obtained; that is, they are presented in the same manner as on the other criteria used in grading the adequacy of prenatal care.

Almost nine-tenths of the women of each racial group had had physical examinations, and the same proportion had had their blood pressure taken and their urine examined. A slightly larger proportion of white than of Negro women received each of these types of care, but differences in the percentages are all too small to be statistically significant.

Pelvic measurements had been made on a smaller proportion of white than of Negro women; the percentages were 65 for white and 73 for Negro women. The percentage for Negro women is significantly higher than that

for white women. This is explained by the fact that a much larger proportion of the Negro women obtain prenatal care from clinics. In the clinic group 97 percent of the women were given pelvic measurements, including internal measurements. On the other hand, only 24 percent of the women who went to private physicians for prenatal care were measured, and there is good reason to believe that in most of these cases the measurements were only external. It is a rule, of course, in the clinics that all patients be measured unless the first visit is dangerously close to term.

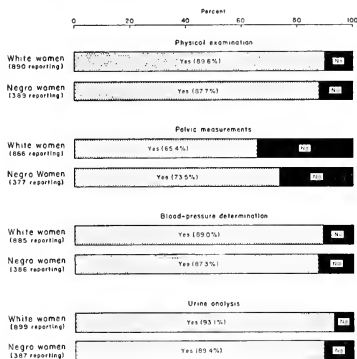


Chart 3.—Physical examination, pelvic measurements, blood-pressure determination, and urine analysis, women who received prenatal care in four Maryland counties, 1938.

The accuracy of the information with regard to physical examinations is open to some question. It will be remembered that the nurses obtained the data chiefly from mothers, who could not be expected to know what an examination should include. It is extremely difficult to make a qualitative assay of these various items. One knows that certain standards are maintained by the clinics, although the quality of the work varies to some extent from one clinic to another. Some private physicians do better work than the clinic, but, on the whole, the tendency of most rural practitioners is to see a large

number of patients without giving very thorough care.

Serologic test for syphilis.—Although it is generally recognized that a serologic test for syphilis is a necessary part of prenatal care, it was not made a prerequisite of adequate care in this study, because many rural practitioners fail to accept a test for syphilis as essential. Information as to whether the test was made was obtained for practically all women who received prenatal care.

Slightly more than two-fifths of the white women (44 percent) had had serologic tests, compared with three-fourths (75 percent) of the Negro. The reason for the higher percentage of serologic tests among the Negro women appears for the most part to be the same as that for the higher percentage of pelvic measurements and is illustrated by the comparison of serologic tests made by physicians and by clinics.

Almost all the women who received care from clinics had tests (91 percent of the white, 99 percent of the Negro), compared with about a third of the white and about two-fifths of the Negro women who received care from private physicians. The taking of a serologic test is standardized procedure in clinics. The fact that the clinics did not achieve 100 percent in this item is disappointing and probably explained by oversight. This should and will be corrected.

In the clinics we attempt not only to make serologic tests on all prenatal patients but to give treatment for syphilis in all instances where the result of the test is positive. At the time of this study about 2.4 percent of the tests on white women and 25.0 percent of the tests on Negro women gave positive results. However, because of lack of cooperation on the part of some patients and difficulty in obtaining transportation to treatment centers only about three-fourths of the women whose tests were positive received any treatment and only about half of the women who started treatment received as many as eight treatments. The number of treatments the clinics were able to give to syphilitic women during pregnancy was also, of course, influenced by the month of pregnancy in which

the woman sought prenatal care. It will be called to mind that one-fifth of the white and two-fifths of the Negro women who received prenatal care from physicians or clinics made their first visit in the third trimester of pregnancy.

Care at Delivery.

Place of delivery.—About three-fifths of the white women and six-sevenths of the Negro women were delivered at home. For women who lived in the country this often meant that the attendant worked under the most primitive conditions. About two-fifths of the white and one-seventh of the Negro women were delivered in the hospital. For a small proportion of both white (2 percent) and Negro women (4 percent) the hospital care was of an emergency nature. It is important, however, that emergency cases comprised only 6 percent of all hospital deliveries among the white as compared with 24 percent among the Negro women.

Attendant at delivery.—Most of the white women were delivered by physicians, whereas about half of the Negro women were delivered by midwives. A very small proportion of the women of each race (0.6 percent) had no attendant at delivery.

Almost all the midwives in these counties are Negro women; none of them have had any institutional training. The State Department of Health, through the public-health nurses and health officers, attempts supervision as far as equipment goes and in matters such as the instillation of silver nitrate in the eyes of newborn infants and the prompt reporting of births. In another county of the State, not included in this survey, the midwives have received intensive instruction, with excellent results, from a trained nurse-midwife who is now doing similar but less intensive work throughout the State.

The percentage of deliveries with no attendant, although low, is higher than in Baltimore City, where, in the 3-year period 1936-38, only 2 unattended births took place.

Type of delivery.—Delivery was spontaneous for 92 percent of the white women and 97 of the Negro women. The larger percentage of spontaneous deliveries in the Negro group is related to the greater number of midwife cases.

Physicians used operative means in delivering 8.6 percent of the white women whom they attended and 6.5 percent of the Negro women. This difference is too small to be considered significant. Women who attend clinics and who have planned delivery by midwives are referred to hospitals or to private physicians if it is thought that the delivery may not be entirely normal. The physicians, therefore, deliver a selected group, particularly in the case of Negro women.

Cesarean section was the operation used for delivery of 25 of the 78 white women and 7 of the 14 Negro women for whom delivery was operative. In the Johns Hopkins Hospital, which receives a large proportion of cases presenting abnormal conditions, 17.5 percent of the operations are sections. This study appears to show a relatively high incidence of Cesarean section among white women, but this may be largely because of the fact that most of the women who received hospital care at delivery were women in serious need of special attention.

Conclusions.

While it is recognized that this survey is deficient in many respects, the chief aim has been descriptive and the general character of the observations with regard to existing conditions seems to be reasonably correct. There are undoubtedly great shortcomings in the care received by rural women, particularly Negro women, in childbearing. These shortcomings are associated with lack of facilities, difficulty in making proper use of the facilities that are available, and the failure of some physicians to give the sort of care recognized as desirable and really essential. The importance of adequate obstetric care for all women must be brought home to general practitioners and emphasis placed on the minimum satisfactory standards for prenatal, delivery, and postnatal care.

The public needs to learn through precept and example what is comprised in good maternity care. This care should be made available to women who cannot provide it for themselves. As adequate obstetric care becomes more general, morbidity and mortality rates for mothers and newborn infants should be lowered.

Some Social Considerations in the Provision of Maternity Care at Public Expense

BY BEATRICE HALL

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The improvement that is taking place today in maternal and child health may be regarded as a culmination of a fundamental concern on the part of citizens, which has actively expressed itself for many years in a variety of programs supported through public and private funds. It may also be regarded as one manifestation of increased awareness on the part of people generally of the influence of social and economic conditions upon the health of mothers and children and the development of greater skill in cooperative effort, making possible a fuller utilization of all community resources in meeting the total problems of individuals.

Early studies made by the Children's Bureau showed the close relationship existing between the health of children and the earnings of the fathers, the manner in which the infants were fed, sanitary conditions, the presence of the mother in the home, and the health of the mother before and after the baby's birth. It follows that the primary medical and social needs of mothers and children can be met only through cooperative work with families on the part of physicians, nurses, nutritionists, health educators and social workers, of health and welfare agencies in both public and private fields, and of professional organizations and citizens' groups.

In the maternal and child-health programs being administered by the United States Children's Bureau under the Social Security Act, the Federal Government, the States and local communities, the medical, dental, and nursing professions, professional and civic organizations, public and private health and welfare agencies are cooperating in a comprehensive partnership. Cooperative planning on a national level is facilitated by national organizations such as the American Committee on

Maternal Welfare, the Maternal and Child-Health Section of the American Public Health Association, and the National Maternal and Child Health Council, a private organization which serves as a clearing house and advisory center for 60 diversified national organizations interested in health problems of mothers and children. In the administration of public medical services cooperative relationships have been developed between departments of health and welfare on State and local levels and other agencies in order to meet patients' needs most effectively.¹

In a study of maternity care provided through the New York State relief program in 1935 and 1936, the Children's Bureau, in cooperation with the New York State Departments of Social Welfare and Health, reviewed the care given in six counties of that State in order to obtain information regarding the extent and cost of the care.² The field work, which was concentrated in the local areas, was done by four medical social workers from the Children's Bureau. In the course of the study recognized gaps in community services and problems arising out of the administration of medical care were brought to the attention of the field workers by local relief and health administrators. Case records also brought to light some problems of general significance in the provision and administration of maternity care concerned particularly with the procedures for authorizing care, the determination of eligibility, relation of medical and social factors,

¹ Cooperation in the Administration of Tax-Supported Medical Care. Committee on Medical Care, American Public Welfare Association, August 1940. See p. 23 for description of a cooperative program for maternity care in Cattaraugus County, N. Y.

² Maternity Care at Public Expense in Six Counties in New York State. Children's Bureau Publication, No. 267. Washington, 1941.

and provision for special needs related to illness. Conferences with local relief and health officials, physicians, nurses, and others also revealed significant problems in relation to the needs and practices of "medically needy" families—those able to maintain themselves but unable to pay for necessary medical care.

The New York State plan, under which maternity care was provided at public expense, and which had been in operation since 1931, was worked out jointly by the Temporary Emergency Relief Administration and the State Department of Health, with the aid of special advisory committees from the State medical, dental, and nursing organizations. The Manual of Medical Care, issued by the TERA, which contained the rules and regulations governing medical care provided in the home to recipients of home relief, included a statement of minimum standards for maternity service which emphasized prenatal care.³ The plan was conceived and administered as a method of supplementing existing resources; it was described by the State relief administration as intended "to augment and render more adequate facilities already existing in the community," such as hospitals, clinics, and nursing services. Under the plan State funds could be used only to assist local welfare departments to pay for care in the home; local communities continued to bear the full cost of hospitalization. While medical care was restricted to persons who were recipients of home relief or who upon investigation by the welfare officer were found to be eligible for home relief, this regulation was interpreted in most welfare districts to include the group unable to pay for medical care, although able to provide themselves with the bare essentials of living. In the counties visited community resources and health

programs differed considerably and illustrated various types of services developed with the help of State funds to supplement local programs. One of these counties included a city of more than 100,000 population in the midst of a rural area; no other cities of as much as 50,000 population were included in the study.

The methods by which maternity care is authorized are of the greatest importance to women needing care, to physicians, to agencies making payment, and to the taxpayers who eventually meet the costs. In the rural areas included in this study, authorizations for home and hospital care were issued by local (town) welfare officers, who worked under the general supervision of the county commissioners. These local welfare officers usually had no medical knowledge and no formal training in social work and sometimes had only a limited general education. The information which they considered necessary in making decisions to grant care was influenced by this lack of knowledge and training. In many instances it was limited to items of family income and current expenditures and did not include explanation of the medical situation, the health needs of the family or other social factors which should be considered in relation to the financial data. Although such information was frequently available to welfare officers through local public-health nurses, it was not consistently utilized as a basis for joint planning in behalf of patients.

Despite the fact that hospital costs were borne entirely by the local unit, no instance was noted of refusal by a welfare official to authorize hospitalization for a maternity patient for whom a physician had recommended hospital care. Some counties had a very high proportion of home deliveries, and unquestionably a much larger proportion of patients would have benefited by hospital care if greater consideration had been given to factors of crowding and lack of proper facilities in the home, distance from the local physician, and so forth, in making choice of home or hospital care. It is significant that in the area where decision as to home or hospital care was based on the medical and social needs of the individual patient 43 percent of the women deliv-

³ The rules and regulations in the manual provided for a high quality of service and recommended that local commissioners of public welfare maintain lists of physicians and other licensed professional attendants who had agreed in writing to comply with them. It was further suggested that when a patient requested the services of a physician not already on an approved list the written authorization to the physician be accompanied by a copy of the rules and regulations and a statement that acceptance of the authorization implied compliance with these rules in giving professional care. In none of the communities studied, however, was there an adequate system of professional review of physicians' records to see that these provisions were being carried out.

ered were hospitalized, whereas in another county which hospitalized only patients for whom the physician recommended hospital care because of complications, 30 percent were hospitalized.

Some welfare officers, however, were not convinced of the advantages of prenatal care and did not encourage applications from women early in pregnancy. There was evidence that this attitude on the part of some welfare officers tended to discourage clients from making early application for prenatal care and that the effectiveness of efforts of public-health nurses to get women under care early in pregnancy was limited in some instances by the efforts of the welfare officers to curtail relief expenditures.

Extension of clinic facilities for prenatal care would have made it possible for women to secure care during this period without the delay incident to determination of eligibility. The prenatal clinic also affords an opportunity for study of the medical and social needs of individuals and the formulation of recommendations helpful to the welfare officer in authorizing care at confinement. In sparsely settled areas, however, clinic facilities cannot always be readily available to all women in need of care, and provision should be made to facilitate authorization for prenatal care by private physicians.

Since the medical need as well as the social situation of patients should be considered in granting authorization for care, procedures of authorization for maternal care should be in the hands of individuals who have an understanding and appreciation of the principles of good maternity care. Ideally, final decision can best be made by a well-qualified physician on the staff of the agency authorizing care, who has been given responsibility for reviewing the report by the physician attending the patient and the recommendation of the social worker who is familiar with the social situation.

It is recognized that great difficulties are involved in introducing such procedures in local administrative units that are not large enough to permit effective and economical administration of medical-care programs under the direction of a physician. A practical temporary solution may be to devise means of giving local

health and welfare workers increased understanding of the basic principles involved in the provision of medical care at public expense and of the social and psychological factors related to health that require consideration in the determination of eligibility. This may be brought about through specialized consultation services from the State staff and through advisory services of district and local health officers and physicians. Since this study was completed, the New York State Department of Social Welfare (to which the functions and powers of the Temporary Emergency Relief Administration were transferred on July 1, 1937) has added medical social workers to its staff and some local offices have made similar appointments. Provision has also been made in some counties for the county medical director or medical consultant to perform the same functions for town welfare departments as for the county department upon the request of the town and upon its agreement to conform to the policies and procedures of the county plan.

Physicians who are giving freely of their skill and time in the treatment of patients on relief rolls have a right to expect the relief administration to provide for the special needs of their patients which are related to the medical problem. A physician treating maternity patients should receive cooperation from the relief organization in early referral of cases; assistance in follow-up unless that responsibility is assumed by another organization; provision for enabling patients to receive a liberal diet in all instances, with special needs met upon the physician's recommendation; help in planning confinement care with the assistance of a nurse if the delivery is to be in the home; housekeeping service and essential household equipment when necessary; and planning for the care of other children in the home during the mother's confinement and convalescence. Anxiety and apprehension on the part of the patient often limit the effectiveness of medical care; it is the responsibility of the social worker and the public-health nurse to aid the physician in dealing with these factors.

In rural areas, where relief offices are staffed by incompletely trained social workers with heavy case loads, meeting these special needs

is a difficult problem. The difficulty is greatly lessened, however, if there is a qualified public-health nurse who serves the area and with whom the relief worker may cooperate. The relief worker cannot provide intelligently for the patient's needs unless she has an understanding of her condition in terms of disability and work capacity, activity limitation, prescribed treatment, and prognosis. She needs to know whether the pregnant woman is able to do all her own housework, whether she needs special food, and whether the physician has made any special recommendations. The public-health nurse can be of great assistance to the relief worker in these circumstances, and the social worker and the nurse can work out a division of responsibility for various phases of treatment of individual patients. Conferences from time to time with a medical-social worker are helpful to local workers in developing policies for co-operative effort and in treatment of individual cases, since the medical social worker is especially equipped to advise on social problems connected with health and medical care.

In some of the areas included in the New York State study the medical needs of clients were effectively explained to relief workers by the county nurses. In one such county, where there was close cooperation between the public-health nurse and the relief-work supervisor, no emergency authorizations for delivery care were noted. In one small city the welfare commissioner and the medical-social worker at the local hospital worked closely together, and in another city the director of the home-relief bureau and the superintendent of the city hospital supplemented each other's efforts intelligently and efficiently. In these areas records gave evidence of a recognition of the interrelationship of medical and social factors; the effectiveness of medical treatment was enhanced by the consideration given by relief workers to the special needs of individuals.

These are a few of the ways in which local relief and health administrators are working together in the provision of maternity care at public expense. General provision of public medical care, including maternity care, is at the present time in many States a responsibility of

welfare rather than health departments. Twenty-five State health departments, however, are providing, in a few areas, medical or hospital care for maternity patients or sick children under plans approved by the Children's Bureau. The Committee on Medical Care of the American Public Welfare Association has expressed its belief that the immediate and important problem is not *who* should administer tax-supported medical care but how it should be administered.⁴ The statement of the committee stresses the fact that the scope and amount of care should be sufficient to include all necessary preventive and curative service required by persons unable to procure it for themselves and that the service should be provided under conditions which will encourage its full use. It is further stated that the medical and social needs of the individual patient should be related and that an effective program for persons on relief should be closely integrated with a general assistance program providing food, shelter, and clothing. Other recommended principles of administration include coordination and integration of services through cooperative relationships eventually leading to centralized responsibility for the administration of preventive and curative services, the adoption of minimum qualifications for practitioners and minimum standards for agencies based on the advice of professional groups and the maintenance of these standards by means of professional supervision.

In planning extension of facilities for maternal care, it is of particular importance to devise procedures for the authorization of care which will make such facilities available to all women unable to obtain care through their own resources. In other words, the determination of eligibility should not be conducted in such a way that the "medically needy" woman will defer making an application for prenatal care in the hope that her financial situation will improve sufficiently to enable her to pay for care. In the statement referred to previously, it is recognized that the determination of med-

⁴ Organization and Administration of Tax-Supported Medical Care; a tentative statement of essentials and principles. Committee on Medical Care of American Public Welfare Association, December 1939.

ical need should be a medical responsibility and should precede the determination of financial eligibility and that procedures for determining eligibility should not delay necessary treatment.⁵ Furthermore, women who apply for maternity care present varying medical and social needs. Consideration of the individual's need is a fundamental concept in the practice of medicine and of social work, and an important consideration in an adequate maternity-care program. The results of medical treatment are influenced profoundly by the availability of re-

⁵ Authorization of care at public expense, as it relates to hospital care, is discussed in detail in a statement entitled "Hospital Care for the Needy," prepared by a joint committee of the American Public Welfare Association and the American Hospital Association and available through the office of either association.

sources to meet these special needs and by the skill with which the services of varied organizations are employed in behalf of the individual. The effectiveness with which the medical and social needs of individual women are met and the extent to which care is available to all women unable to meet their own needs is the real test of any community program for maternity care.

Consideration of an individual problem encountered in the provision of care may reveal gaps in community resources, limitation of programs through inflexible and restrictive policies, or failure to correlate essential services in meeting a total situation. Such problems constitute focal points for concerted action by the community.

Nutrition Defense Committees

BY HELEN S. MITCHELL, PH. D.

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Any attempt to reach the 130 million people in the United States with an action program to meet their needs in terms of food must be made by people who understand the varying local problems and resources of different parts of the country. Some State nutrition committees were already in existence when the national nutrition program was conceived as a defense activity, and these were used as a nucleus for Nation-wide cooperation with Federal authorities in translating nutrition information into action. The National Nutrition Conference for Defense, which was held in May 1941 at the call of Federal Security Administrator Paul V. McNutt and of the National Nutrition Advisory Committee, stimulated existing State and local groups to increased activity and inspired other States to set up similar organizations. By July every State, as well as the District of Columbia, Hawaii, and Puerto Rico, had its own nutrition committee with broad representation from public and private agencies. Today several States have set up their programs on a county basis. The unit of organization in the local level is, of course, the neighborhood or community.

Functions of a Nutrition Committee.

Leadership in developing a nutrition program best suited to the needs and conditions of a particular area rests with its nutrition committee, but in general their activities follow similar patterns. Before a committee can begin to develop a program, it must, of course, survey nutrition activities of existing agencies and ascertain to what extent these are meeting the needs of its people—geographically, economically, and socially.

In the light of the knowledge thus obtained and of whatever other information is available, including pertinent studies, each committee has then tried to analyze the nutritional situation in its State to determine the most urgent needs—those requiring immediate attention—and to decide by what means they can best be met.

Membership of the Committees.

Not all nutrition committees follow the same pattern in their organization, but most of them include representatives of State agencies in the fields of agriculture, home economics, health, welfare, and education. In addition, many State

nutrition committees include representatives of the Farm Security Administration, the National Youth Administration, the Surplus Marketing Administration, and the Work Projects Administration. Other Federal agencies, such as the Children's Bureau, the Extension Division of the Department of Agriculture, the Office of Education, the Social Security Board, and the Public Health Service are represented indirectly through the State agencies that are carrying on programs under Federal grants-in-aid. Private groups from which membership may also be drawn are State medical, dental, nursing, dietetics, and home-economics associations, private health and welfare agencies, schools, colleges, labor auxiliaries and racial group associations and other lay organizations. The American Red Cross, a quasi-government agency, is frequently represented.

In short, every agency that carries on nutrition activities in the area and is willing to cooperate in the National and State nutrition program, is a potential member of the State or local committee.

Interrelationships.

Relation of national office to State nutrition committees.—In the National Office of the Director of Defense Health and Welfare Services, M. L. Wilson is the assistant director in charge of nutrition. About once a month a news letter goes out from this office to all State nutrition committee members. Thus State workers are acquainted with developments in the national program and in other States. Frequently these news letters contain discussion of subjects requested by State committees or suggestions regarding organization or specific activities. They also contain notices of available materials, such as folders, pamphlets, exhibits, and nutrition scrap books. Whenever possible, the Nutrition Division is glad to respond to requests for speakers at regional or State nutrition conferences.

Relation of State committees to county and local nutrition committees.—County and local nutrition committees have been organized in many States with the encouragement of State committees. Through these, especially when set up in cooperation with local defense councils, the citizen can readily find a means of joining

an action group to promote better nutrition in his own community through a variety of projects. These vary widely—preparing news releases for the local press and radio; promoting discussion and study groups; setting up exhibits and distributing posters; assisting in the school-lunch program; and working with food purveyors and distributors to educate the public.

Another important avenue through which the local committee brings nutrition information to members of the community is the local library. The American Library Association has recently published a nutrition bibliography in *Booklist*, which goes to 7,500 member libraries. Public demand for up-to-date and authoritative information on nutrition will encourage libraries to order these materials.

Relation of nutrition committees to State and local defense councils.—The work of the nutrition committees obviously ties in closely with that of State and local defense councils under the Office of Civilian Defense. To fit in with their plans to have an information center in each locality where the willing volunteer may learn the requirements of various projects, a Manual on Nutrition in Defense is being prepared in Washington.

Activities Reported by Nutrition Committees.

Many committees are already reporting good results from several types of activities.

Refresher courses were held during the summer in 18 State colleges and universities. These were attended primarily by home-economics teachers, home-economics-trained home makers, home demonstration agents, Farm Security Administration workers, and social workers from departments of public welfare.

State-wide conferences or nutrition institutes lasting 1 to 3 days or longer have been found successful in several States as a means of orienting a community or group in the aims of the national nutrition program. In some States these conferences have been called by the Governor. One State held a nutrition institute attended by 102 Negro preachers who, according to reports, are spreading the message of better nutrition most effectively in their parishes. In Ohio the committee organized five regional institutes during the spring as a result of which a State-wide refresher course was given in con-

nection with a nutrition conference. The California committee has sponsored a 2-week defense nutrition institute. The third annual nutrition institute in New York State was held at Cornell University in July.

Adult classes in nutrition have been organized in a few places and are received with enthusiasm. In Virginia 200 white women and 84 Negro women completed such a course, and more courses are being planned. Mattress centers of the Work Projects Administration, where people are using surplus cotton for making mattresses, are also being used as teaching centers for giving information on nutrition to workers.

Speakers' bureaus, set up in some localities, assist clubs and other organizations to include nutrition in their programs.

Community gardens and community canning projects.—Of the many community gardens established this summer those especially successful were in Negro communities where they had never had gardens before. Many of the gardens were on school grounds, and the canning was done at community canning centers.

School-lunch programs are being planned on

an extended and improved basis in most States, thanks to help from Surplus Marketing and Work Projects Administration. In many communities where they were needed acutely they have proved an excellent starting point for a community nutrition program.

A Look Ahead.

All this is only a beginning. Much of the work of the committees so far has been of an experimental nature, a trying out of various methods and activities. As they find the avenues of approach that appeal most to their people and meet most effectively conditions in their own States, results should be increasingly helpful. These results should show first in improved food choices, such as an increasing demand for "enriched" or whole-wheat products, and in more effective use of surplus commodities and more widespread home growing of vegetables. Ultimately the value of the nutrition program should prove itself in terms of health and well-being, improved physical and mental stamina for millions of people who, whether they know it or not, have lacked the health and vigor that comes from an abundant and well-chosen diet.

Civil Defense Measures for the Protection of Children, Dr. Martha M. Eliot's report of observations in Great Britain, February 1941 as a member of the Civil Defense Mission to Great Britain, has now been released for publication. A limited number of copies of the report in mimeographed form are available from the Children's Bureau for the immediate use of local administrative authorities.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Interpreting Child-Welfare Services in Rural Areas¹

By RUTH M. WERNER

Children's Worker, Walworth County, Wis.

At a club meeting in a rural county the child-welfare program was being discussed. Child-welfare services had been in operation in the county for more than 2 years, and the governing board of the county had reached the point of considering whether the program should be made a permanent one, supported by county funds. One woman said:

You need expect no support from me in keeping that child-welfare worker. She hasn't done a thing to get that Sue out of this town. There Sue sits with her two children. No one knows who the father of either one is, and I hear there'll be another soon; at least I wouldn't be surprised. Everyone knows Sam's been living up there and supporting her all winter, and you can't tell me they're married, either.

But another woman protested:

Well, that may all be but if there's anything I can do to help you can count on me. If Miss Frank hadn't done one other thing, what she did for Janet Schmidt and her little 2-year-old child would convince me that she is someone worth having around. You know the Schmidts were living near us when Ted came home drunk and beat that baby until he was black and blue all over, even his ears. Miss Frank came out to see what was wrong, and it didn't take her long to see that Janet and the baby were taken care of, and Ted, too.

The importance of first-hand knowledge of case-work services in influencing individuals is shown by this bit of discussion. No less important than case-work service is the interpre-

tation of the program to the community in the light of case-work principles.

The problem of interpretation in a rural county is different from that in an urban setting where social agencies and publicity channels are well-established. Into a rural county comes one worker whose responsibility it is to develop a program of child-welfare services in such a way that the people of the county will find this service essential and therefore decide to make it permanent.

Although each county, like each individual case, presents a different set of factors and no two can be handled exactly alike, there are a few general principles that can be applied in work with counties.

To begin with, need for the services must be felt by some group, perhaps the juvenile court, perhaps the county parent-teacher association or federation of women's clubs, perhaps the men's service organizations. This consciousness need not be general throughout the county, but it is the responsibility of the State worker to see, before a local worker is assigned to a county, that there is some group to which she may look for understanding and help in relating the program to the larger community.

The worker must obtain some information about the county as the basis for diagnosing the needs and making plans. How do the residents think of the county? What national and religious groups are to be found? What is the economic situation? What are the sources of tax funds? What government units are there?

¹ Paper given at joint session of the Child Welfare League of America and the Social Work Publicity Council at the National Conference of Social Work, Atlantic City, N. J., June 3, 1941.

Some of this information comes from collateral sources and some from people within the county. The worker in turn discusses her services in general terms and gives examples, always following leads which the community offers as she would follow leads in a case-work situation. Just as every worker must make clear to people in need of help how her services are related to their needs, a rural worker must present to the county the services offered by the whole child-welfare program. Here the ability of the worker to understand and to accept the local situation, to like the people and be liked by them, is important.

The worker realizes that services related to problems which the county recognizes, and for which help is asked, have most meaning to the county. As the relationship between the worker and community grows stronger, there will be a broadening of the base of understanding and a growing acceptance of the wider range of services which the worker can offer. The readiness to recognize need for services varies from individual to individual and from group to group. It depends on the nature of the problems presented, on whether help is desired, on the extent to which the worker is accepted, and on the degree to which the services are understood. When groups within the county are convinced that the services are essential, they in turn act as interpreters, and general understanding and acceptance gradually become sufficient so that the services are organized as a permanent county function. In this connection, some remarks of Dr. Krueger's seem applicable. He states:

Educating a community calls for skillful approaches and it will be accompanied often enough by heart-breaking failures to get local residents to overcome their own warped attitudes toward problem families and persons. We venture the suggestion, however, that communities can learn to deal with their problems and that when they succeed, we shall have a powerful aid in creating a preventive program.²

This would entail a shift from the case-work processes. When a person gains complete understanding of his problem, he should have

a better integrated personality with less need for social service. But only a beginning has been made in the establishment of a permanent program in a community when the community as a whole has recognized its problems, understood the need for social services in dealing with them, and accepted responsibility for organizing such services.

In the county which I shall use as an illustration, there was a group which was conscious of the need for child-welfare services—the county parent-teacher association. The State representative of the Children's Division had been working with this group for 2 years. Although not county-wide in scope, the group had called a county-wide meeting which resulted in requests to the State office for the service. The worker went to the county in response to these requests. The executive committee of the county parent-teacher association formed the nucleus of an advisory committee. Other members were the juvenile-court judge, the county superintendent of schools, and the director of the public-assistance agency. They felt from the beginning an interest in the program; it was theirs.

From the State worker and her records, the worker learned some facts about the county. More were learned in day-to-day contacts with members of the advisory group. The county is entirely rural and has a population of less than 10,000. It has poor soil, and the people must struggle for a living; but the public-assistance load has never been high, and the county has remained free of debt. This has been accomplished partly by the conservative policy of the governing body of the county which preferred to refuse FERA funds rather than to accept outside supervision. Only a year before the worker came in, the county rejected an offer from the State Board of Health to subsidize a public-health nurse to the extent of \$2,000 if the county would appropriate \$500. A strong conservative group in the northern part of the county supported these policies.

In the southern part of the county, the struggle between fundamentalists and modernists has caused rifts in churches and communities. Religious friction has affected the

²Krueger, E. T. Community Planning for Preventive Services. *Bulletin of Child Welfare League of America*, January 1940, p. 3.

lives of young people by limiting the recreational program of the schools. As a result, the young people flocked to taverns and public dance halls in connection with the taverns.

There was a county federation of women's clubs in addition to the parent-teacher association, but neither one extended into the northern section of the county.

The county had experienced almost no professional service in the field of social work. The public-assistance agencies had limited their services to reporting financial needs with Federal aid.

As the worker began to function in this setting, it was necessary for her first to explain to the advisory committee and to key people in each community what services she could render. The committee met monthly, and in addition to a report on the worker's activities, discussed some phase of a program of child-welfare services: Foster homes, adoption, or work with unmarried parents and the child born out of wedlock. A foster-home study was presented to the group to show what the worker looks for in a foster home. The State consultant on adoptions discussed her field of interest with the group. The worker called on the ministers, physicians, and school principals throughout the county explaining her work. And at this stage committee members arranged for the worker to meet with groups in various communities. This interpretation served to give a basis for understanding to many people before they had contact with the program through cases.

About a year after the worker had come into the county, she visited a family in which the parents were separated and the mother was experiencing difficulty in maintaining a home for her 11-year-old daughter. At one time the mother had gone to work and placed Mary with her grandmother. Mary had not liked this and, when a return to this plan was suggested, Mary said to her mother, "Let's talk to Miss Frank first. I heard her talk at school, and she cares about what happens to children." So, in at least one instance, someone in the audience was able to relate the services as outlined to her particular problem!

At this early stage, as always, service rendered in individual situations was the most effective means of interpretation. In accepting cases referred to her by other agencies, and in reporting on them, the worker had an opportunity to explain how she could be of service and to stimulate thinking in relation to a recognized problem.

Three months after the worker arrived, a case of serious neglect and abuse came to the attention of the juvenile court when the father of four children was jailed. The mother had deserted. The judge of the juvenile court had been in office only a few months. He was open-minded but wondered if there was any need for child-welfare services in this small and rural county. The judge told the worker that perhaps she could be of some help, but that he thought he already knew what he would do with these children; he would send them to the Catholic institutions maintained by the diocese. The worker agreed that this might be a good plan but suggested that perhaps a study made in the community would be helpful to the Catholic agency. It was found that the boy, 12 years of age, had been with his grandmother a great deal. He was the child most upset by the whole situation. A study of the grandmother's home showed that she was willing and able to care for this child. For the other three children the Catholic agency did seem the best solution, for this agency had a flexible program offering both institutional and foster-home care, whereas the child-welfare service was so new in the county that a foster-home program had not been started. The worker got in touch with the Catholic agency. The fact that the worker was able to relate her services in an acceptable fashion to a problem confronting the judge marked the turning point in his attitude; he became a staunch advocate of the program and considered it a service he could not get along without.

In a rural area, far more than in an urban one, the citizenry generally are aware of families receiving service. If results in one case prove to be to the interest of the community, support for the program is forthcoming; but if it is believed that the measures taken were not drastic enough, criticism is sure to follow. This fact emphasizes the need for a general understand-

ing that the service is a helping one, not a punishing one. Such an understanding also enables people to accept service without feeling stigmatized. A continuing educational program, then, is needed in addition to case-work services; this program should be designed to meet varied levels of understanding.

Here again the advisory committee members were helpful. They received monthly reports on the number and kinds of requests for service, the cases closed, and the services that had been rendered. They did some reading suggested by the worker. Some of the members attended State conferences and regional meetings of the Child Welfare League of America. The committee members were growing in understanding and ability to answer inquiries regarding the program, to straighten out misconceptions. They were better able to bring to the worker an understanding of community attitudes.

While the committee was developing to the point where it could take an active role in the educational program, the worker was becoming a part of the county so that her fellow citizens began to say, "Miss Frank belongs to us." She attended church services in the various communities, church suppers, school programs, the educational workshop, basketball games, and public card parties. She learned to know people on a friendly plane. They accepted her as really one of them because she shared their experiences. As they learned to know her informally, they also got some inkling of the nature of the service which she represented, for the worker represented the service in everything that she did and said.

With the preliminary work completed, the time came to solidify the program in the community with greater public understanding. The worker followed the leads that were offered. The county governing body was the key group, since it had the power to decide whether the service should continue. It received a report from the committee and from the worker. The worker's report was mimeographed on colored paper, and placed special emphasis on what the services save in dollars and cents, hard though that may be to estimate. But how much did the members of the governing body really know and understand of what was being done?

"Why not send them a questionnaire and find out?" the judge suggested when this was discussed in committee 6 months after the program started. He agreed to help work out the questionnaire.

Has the child-welfare worker done any work in your town or village which in your opinion was necessary?

Do you believe such work saved your town present or future expense?

Did such work help the children involved?

Would it have been done without the services of the worker?

Are the people in your town aware of the services which the worker will give if requested?

Do you know of anyone needing her services now?

So ran the questions. Surprisingly, 17 of the 21 of the questionnaires were returned, and the replies were favorable to the child-welfare work. One suggested that a list of services would be helpful. This was the next lead. A mimeographed folder which would fit in a business-size envelope was made on colored paper with illustrations. It gave the aim of the program and listed family situations and children's problems³ with which the worker might be able to help. Five hundred of these folders were sent to physicians, attorneys, ministers, and were distributed at meetings at which the worker talked and at county fair exhibits.

Exhibits at county fairs provided another opportunity to bring information to the citizens of the county. One year a bad home situation was contrasted with a foster home in doll-house fashion. Another year, a toy Ferris wheel was used. Each section illustrated an influence which children need: a good home environment, the school, the church, wholesome recreation, community protection. These served as attention-getting devices and gave the worker opportunity to discuss the program with individuals who might otherwise have had no contact with it. Maps and charts were used in presenting facts.

Free outdoor motion pictures attract large crowds in rural sections during the summer months, and the advisory committee was able to arrange with the local sponsors to show slides calling attention to the child-welfare services.

³ Child Welfare in a Wisconsin County. *The Child*, vol. 3, No. 12 (June 1939), p. 269.

A sketch of a donkey kicking up his heels carried the caption, "Don't kick about your troubles. See your children's worker." A little boy on a stepladder called attention to the scope of the service with the statement, "Climbing up!! One hundred forty-eight children from 50 different families in this county helped by the children's worker during May alone." Five such slides were rotated in four communities in the county throughout the summer months. One parent, after seeing these slides, for the first time realized that the worker with whom he had had casual contact was particularly interested in helping with children's problems, and he came in to ask help with a nervous, high-strung youngster who was reacting unfavorably to the financial pressure and uncertainty in the family situation.

The weekly newspaper printed special articles and reprinted the reports to the county board. A person visited in a section of the county where the worker had done little, immediately identified "the children's worker about whose work I've been reading."

In the various ways mentioned efforts were made to spread information and understanding of the service, but it was recognized that participation in the program is important. A member of the committee and the worker prepared a panel discussion to meet this need. It was in the form of a conversation to be read by the worker and two members of the group with whom the program was being discussed. This was a start. Then packets of material were distributed by the committee to ministers and local discussion groups. These packets included general information on child welfare, the Children's Bureau pamphlet⁴ entitled "Com-

munity Social Services for Children," information regarding the State program, the folder describing the services offered locally, and information on how the program was set up and its scope. The individuals and groups to whom these packets were given were asked to present to their groups discussions based on this material. It was thought that the persons who studied the material would gain a better understanding of the program, and that having the discussion led by a member of the group would result in more participation.

The educational program now plays a supporting role to services rendered to families and individuals and after 2½ years the citizens of this county are aware of the value of child-welfare services to their county and are interested in having the service continued. It was in response to this feeling on the part of the citizenry that the governing body of the county took favorable action.

This county has its own problems and characteristics. The techniques used in interpreting child-welfare services here may not be applicable elsewhere, but the underlying philosophy on which the techniques are superimposed would seem to have general application. It is important that the county, or at least some group in it, should recognize the need for help with child-welfare problems. Then the worker must come to understand and know the community. Services must be interpreted in relation to needs which the county recognizes. An educational program must accompany case work and give support to it, but case work itself is the most effective means of education. As the people of the county recognize that the service is meeting their needs they will assume responsibility for making it permanent in the county.

⁴U. S. Children's Bureau, Folder 7 (revised). Washington, 1939.

BOOK NOTES

Plays for young people—The Drama Magazine for Young People is a new periodical published by Plays, Inc., Boston, Mass. The first number is dated September 1941 (Boston, 1941, 96 pp.). This issue contains 16 plays and radio scripts designed for performance by pupils in grade schools with the purpose of instilling in them an appreciation of democratic traditions. It is announced that the magazine will be published monthly from September through June at a price of 30 cents a copy, or \$3 a year.

* * * * *

HOW TO TEACH CHILDREN MUSIC, by Ethelyn Lenore Stinson. Harper & Bros., 1941. 140 pp. \$1.50.

This book relates the experience of the author in planning and adapting a course in the study of music appreciation for the exceptional children in the Woods Schools at Langhorne, Pa. The course of study, methods of teaching, and approach to the problem, which succeeded in helping each of these children to find beauty and inspiration in music, should be of value to teachers of normal children who can learn more quickly than the children at Langhorne but who may be untalented or without interest in music.

By the use of large instrument charts and pictures of instruments and artists the children were given an opportunity to use and develop their visual memory. By the requirement that each child do a certain amount of handwork, the use of the kinesthetic sense was encouraged. Phonograph records and radio programs stimulated the auditory images of the children.

Texts and reference books, with an explanation for the use of each, are listed by the author. Changes are suggested in the usual procedure of teaching music appreciation in order to make it easier for the children.

PHYSICAL EDUCATION FOR SMALL ELEMENTARY SCHOOLS, by Harold K. Jack. A. S. Barnes & Co., 1941. 184 pp. \$1.60.

The author, supervisor of health and physical education of the Minnesota State Department of Education, presents a detailed program for teaching physical education to children in small and rural elementary schools. Games, stunts, and drills for use in all eight grades are suggested. The book contains chapters on the techniques of teaching physical education and the objectives of elementary-school physical education.

PLAY FOR CONVALESCENT CHILDREN IN HOSPITALS AND AT HOME, by Anne Marie Smith. A. S. Barnes & Co., New York, 1941. 133 pp. \$1.60.

That a directed play program can be a constructive experience for children during the several phases of hospitalization is the theme of this book. Play is discussed as part of an integrated hospital program contributing to an understanding of the child, to development of his mental and social potentialities and his education, and as one of the several forms of therapy available in the well-equipped medical unit.

A play program as described here is more than the provision of play equipment to keep the child occupied and quiet. Its soundness and value are based on an understanding of the psychology and needs of children individually and as members of a social unit and on professional development of such a program by personnel educationally and personally suited for the responsibility.

The emphasis of the author is on the well-rounded hospital program to meet total needs of the whole child rather than "play" itself. Illness is recognized as imposing physical restrictions on the child as well as affecting his temperament and personality. Although the interplay of physician, nurse, social worker and play-program personnel is both mentioned and implied, the interaction and interrelation of their respective services in relation to particular situations could be further developed with value.

As Miss Smith points out in the foreword, "Although this book deals with the child in the hospital situation, the activities, the principles, the values of play and of group methods are applicable to children anywhere." The book should be of considerable assistance to individuals participating in a play program since it treats organization and administration of such a service, techniques of play leadership, and content of program. Included are suggestions for literature, games, and activities which require and which do not require material equipment.

The discussion is based on observations of a 6-year experience at the Children's Memorial Hospital, Chicago, where an experimental development was the co-operative venture of the Sociology Department of Northwestern University, the School of Pediatric Nursing of the Children's Memorial Hospital, and staff members of that 250-bed hospital. Introductory and advanced courses were developed for student and staff nurses and additional sessions prepared for other hospital personnel. It would appear that from this theory and practice the nurses increased their understanding of children and their ability to work with them for effective nursing care.

R. T.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

The Census Counts the Child Workers of the Country

By BEATRICE McCONNELL

Director, Industrial Division, U. S. Children's Bureau

In 1790, within a year after the election of its first President, the new Republic of the United States of America began the series of Nation-wide counts that at 10-year intervals ever since have given a picture of this country and its people. That first census, covering population only and taken for the purpose of determining the representation of the individual States in the lower House of Congress, was the beginning of periodic and increasingly comprehensive inquiries that have been of incalculable value in determining the extent and trend of the social changes occurring during a century and a half of our national life.

The growing complexity of our national problems may be indicated to some degree by a comparison of the 4-million population of 1790 with the 132 million of 1940; of the 6 or 7 simple queries of that first census with the hundreds of questions now included in census schedules dealing with population, agriculture, and manufactures.

The facts which these censuses reveal serve to illumine many social problems—problems as varied as the individuals that make up the people of this country. One of the most vital measurements for which people look to these figures is that of the employment of children and youth. It was not until 1870 that the special problems of child labor were recognized as of sufficient importance to demand the attention of the national census, although occupational data for all persons 15 years of age and over had been obtained in the censuses of 1850

and 1860. With the year 1870 information about employment of children 10 to 15 years of age inclusive was obtained, and this practice was followed until 1940, when the information obtained on employment of children was limited to those 14 years of age and over.

Tabulation of the complete census findings requires a period of many months, and in order to furnish as soon as possible a general picture of the more important facts gathered, preliminary estimates based on a 5-percent cross section of the population enumerated in each of the 154,000 census-enumeration districts have been compiled. These figures are, of course, subject to correction when the final statistics become available.

According to these preliminary estimates there were in round numbers 4,800,000 boys and girls 14 and 15 years of age in the United States in March 1940 (4 percent more than in 1930), and 4,900,000 boys and girls of 16 and 17 years (5 percent more than in 1930). These numbers include all children of these ages, regardless of whether they were in the labor market, in school, or otherwise occupied. As the amount and kind of employment of young persons is to a large extent dependent upon work opportunities, the type of locality in which these children live is significant. The number of boys and girls 14 to 17 years of age, inclusive, living in rural nonfarm areas was markedly greater in 1940 than in 1930—an increase of 15 percent—and the number living in urban areas also increased, though to a less degree. In rural

TABLE 1.—Population 14 to 17 years of age, inclusive, in urban, rural nonfarm, and rural farm areas, United States, 1930 and 1940

Area and population group	14 to 17 years inclusive			14 and 15 years			16 and 17 years		
	1930	1940 ¹	Percent change	1930	1940 ¹	Percent change	1930	1940 ¹	Percent change
United States, total.....	9,341,221	9,749,150	+4.4	4,678,084	4,843,381	+3.5	4,663,137	4,905,769	+5.2
Urban.....	4,704,237	4,995,454	+6.2	2,330,954	2,457,440	+5.4	2,373,283	2,538,014	+6.9
Rural farm.....	2,902,991	2,762,140	-4.9	1,470,081	1,385,382	-5.8	1,432,010	1,376,758	-3.9
Rural nonfarm.....	1,733,993	1,991,556	+14.8	876,149	1,000,559	+14.2	857,844	990,997	+15.5

¹ Preliminary figures, estimated on the basis of a 5-percent sample tabulation of the 1940 census returns.

Source: 1930—Fifteenth Census of the United States: 1930, Population, vol. III, pt. 1, p. 17. 1940—Unpublished data from U. S. Bureau of the Census.

farm areas, on the other hand, there was a decrease of 5 percent between 1930 and 1940 in the number of children of these ages (table 1).

Although because of differences in definition the 1940 census figures for employment were not collected on the same basis as those for 1930, the number of young persons recorded as "in the labor force" in 1940 may be compared roughly to the number recorded as gainful workers in 1930. The "labor force" in 1940 was defined on the basis of employment status during the week of March 24-30. It comprised, first, persons actually having jobs in private employment or nonemergency Government employment; second, those at work on Government emergency projects; and third, those out of work but actively seeking employment during the week when the census enumeration was taken, including a considerable number of new workers who had never held a job. The 1930 data on gainful workers comprised all persons usually following a gainful occupation, regardless of their employment status at the date of the census (April 1, 1930). It is probable that considerable numbers in certain groups—for instance, seasonal workers neither working nor seeking work at the time of the census—were included among gainful workers in 1930 but, in general, were not included in the 1940 labor force. On the other hand, the 1940 census includes in the labor force persons seeking work without previous work experience—that is, new workers—few of whom were included in the 1930 group of gainful workers.

Child labor in the decade 1930-40 was influenced by many factors having a tendency to re-

duce the numbers of children employed. These factors included a decline in employment opportunities for all workers and also advance in legislative child-labor standards, both State and Federal. It is not surprising to find, therefore, that the number of working children 14 to 17 years of age, inclusive, and particularly those 14 and 15 years of age, decreased considerably during this period, despite the slight increase in the total population of this age group previously noted. Nevertheless, the census figures show that in 1940 more than a quarter of a million children 14 and 15 years of age, and more than a million boys and girls of 16 and 17 years were in the labor force of the country. The number of 14- and 15-year-old children reported as in the labor force in 1940 was 41 percent smaller than the number of children of the same ages reported as gainfully employed in 1930, and the corresponding difference for the 16- and 17-year-old group was 29 percent (table 2).

About two-thirds (890,976) of the boys and girls 14 to 17 years of age inclusive in the 1940 labor force were reported as actually employed, including 213,104 children of 14 or 15 years and 677,872 of 16 or 17 years. These figures represent, in general, boys and girls employed during the week March 24-30 on private jobs or Government work of nonemergency character.¹

¹ Although there is reason to believe that the 16- and 17-year-old group includes a few thousand young persons who were on National Youth Administration student-work projects or in Civilian Conservation Corps camps and who should, therefore, have been reported as emergency workers rather than as employed, this error was probably too small to distort seriously the total figures on employment.

TABLE 2.—*Number of children 14 to 17 years of age, inclusive, in labor force in 1940, compared with number of gainful workers of same ages in 1930, by sex, United States*

Sex of children	14 to 17 years inclusive			14 and 15 years			16 and 17 years		
	1930	1940 ¹	Percent change	1930	1940 ¹	Percent change	1930	1940 ¹	Percent change
Total.....	1,910,631	1,302,652	-31.8	431,790	255,336	-40.9	1,478,841	1,047,316	-29.2
Male.....	1,202,976	924,052	-26.8	298,482	198,941	-33.3	964,494	725,111	-24.8
Female.....	647,655	378,600	-41.5	133,308	56,395	-57.7	514,347	322,205	-37.4

¹ Preliminary figures, estimated on the basis of a 5-percent sample tabulation of the 1940 census returns.

Source: 1930—Fifteenth Census of the United States: 1930, Population, vol. V, p. 345. 1940—Unpublished data from U. S. Bureau of the Census.

They do not give a complete picture of the extent of employment of boys and girls under 18 years of age, as they do not include working children under 14. The 1930 census recorded a total of 235,328 workers 10 to 13 years of age inclusive—205,563 in agricultural work and 29,765 in nonagricultural work. This figure for 1930 was generally considered to be an understatement, because of the very large number of young children known to be employed in certain occupations, particularly in industrialized agriculture, street trades, and industrial home work. How many were employed in 1940 cannot be definitely stated, but there can be no doubt that employment of children of these ages still continues.

In both years the fact that the census was taken in early spring inevitably resulted in omitting from the count many children of the ages covered employed in agriculture. Although some commercial crops are under cultivation as early as April 1, the vast majority of the children who engage in industrialized agriculture are not employed at that date and would not have been counted in the labor force as they would not have been regarded in the last week of March as "seeking work."²

² A farmer who usually operated a farm was recorded as employed even though because of bad weather conditions, or other reasons, he did not actually work on the farm during the given week; but his children, to be recorded as at work, must actually have worked during the week on tasks contributing to the income of the farm (other than home housework, occasional work, or incidental chores). It is, therefore, probable that some children may have been counted in 1930 as having the "usual occupation" of farm work, whereas in 1940 children in the same status would not have happened to work during the given week and would not be counted as in the labor force, for they would not have been thought of as "seeking work."

No figures showing the industries in which children were employed in 1940 are as yet available. However, the relative numbers of young workers resident in urban, rural nonfarm, and rural farm areas furnish some indication of the distribution of children employed on nonemergency work as between agricultural and nonagricultural employments. Sixty-eight percent of the employed children of 14 or 15 years reported by the census lived in rural farm areas and only 19 percent, in urban communities. Among the 16- and 17-year-old workers, the concentration in farm areas was somewhat less, but farm residents nevertheless made up 49 percent of the group, compared with 35 percent who were urban residents and 16 percent who lived in rural nonfarm areas.

A reduction in employment of children, particularly those under 16, such as is indicated by the 1940 census figures, is to be regarded as a social gain, as it means a lengthening of the period open to the coming generation for schooling and for physical and mental development. But labor statistics are seldom static. Already greatly expanded production, under the defense program, is directly affecting the employment of young persons. There has been a sharp increase in employment of boys and girls 16 and 17 years of age, and, along with this, there is evidence that a rise is also occurring in the employment of children under 16. Any upswing in general employment tends to be accompanied by an increase in child labor; in addition, the present emergency is inevitably causing pressure on child-labor standards. It is vitally important that such pressure should not be permitted to fall upon the children of

the Nation who, more than ever before in our history, need all possible opportunities for train-

ing to fit them for the heavy responsibilities awaiting them in the future.

International Labor Conference

New York, October 27, 1941

The International Labor Conference which will open in New York on October 27 is the first since the Conference held in Geneva, Switzerland, in June 1939. The Conference scheduled for 1940 was postponed because of the outbreak of war in Europe.

The agenda includes a report by the International Labor Office on collaboration of organizations of public authorities, workers, and employers. The report of the Acting Director, Edward J. Phelan, will present a broad survey of the main economic and social trends for the past 2 years and will outline the future policy of the International Labor Organization, which at present has headquarters in Montreal.

The Washington Office of the International Labor Organization has issued a release stating that representatives of governments, work-

ers, and employers of various nations throughout the world will attend the New York Conference. All general sessions of the Conference will be open to the public.

The first International Labor Conference, October–November 1919 was held in Washington, D. C., and a technical conference on the textile industry was held by the International Labor Organization in Washington in 1937. Two special regional conferences, one in Santiago, Chile, in 1936, and the second at Habana, Cuba, in November–December in 1939, have been held in the Western Hemisphere. Except for the 1919 Conference, however, all general conferences of the International Labor Organization have been held at its former headquarters in Geneva.

Maternal and Child-Health Examinations

Examinations for positions as specialist in maternal and child health with the Children's Bureau (\$3,200 to \$5,600 a year) have been announced by the United States Civil Service Commission. Options are offered in pediatrics, obstetrics, or orthopedics. Vacancies in State agencies cooperating with the Children's Bureau may be filled from these examinations at the request of the States. Application forms can be obtained from the Civil Service Commission in Washington, from the United States Civil Service district offices, or from first- or second-class post offices; applications must be on file not later than November 15, 1941.

CONFERENCE CALENDAR

- 1941
- Oct. 9-11 American Academy of Pediatrics. Annual meeting, Boston, Mass. Secretary: Dr. Clifford G. Grulee, 636 Church Street, Evanston, Ill.
- Oct. 20-26 Better Parenthood Week. Material and information from Better Parenthood Week Committee, c/o *Parents' Magazine*, 52 Vanderbilt Avenue, New York.
- Oct. 27-
Nov. — International Labor Conference, New York.
- Nov. 2-8 Children's Book Week. Twenty-third annual observance. Book Week Headquarters: 62 W. 45th Street, New York.
- Nov. 9-15 American Education Week. Information and Material from National Education Association, 1201 Sixteenth Street NW., Washington.
- Nov. 11-14 Southern Medical Association, St. Louis, Mo.
- Nov. 12-14 Eighth National Conference on Labor Legislation, Washington. Called by the Secretary of Labor.
- Nov. 14-15 Child Study Association of America. Two-day institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.
- Dec. 4-6 National Society for Prevention of Blindness. Annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.
- 1942
- April 6-10 Second American Congress on Obstetrics and Gynecology, St. Louis Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago, Ill.
- May 2-9 Eighth Pan American Child Congress, Washington, D. C. (Postponed from March.)

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at \$1 a year; foreign postage, \$0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

Social Statistics

Supplement Number 1, September 1941

to

THE CHILD—Volume 6



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The SOCIAL-STATISTICS SUPPLEMENT is issued by the Children's Bureau four times a year, in connection with the Bureau's monthly publication, THE CHILD.

The purpose of the supplement is to make available for general use summaries of current social statistics related to child welfare, prepared by the Bureau's Division of Statistical Research. While material presented in the supplement will be based largely on reports forwarded by health and social agencies in connection with the Bureau's project for the registration of social statistics, closely related material from other sources will also appear from time to time.

SERVICES OF STATE HEALTH DEPARTMENTS FOR MOTHERS AND CHILDREN, 1940

Maternal and child-health services administered and supervised by the several State health departments 1/ and regularly reported to the United States Children's Bureau form the basis of this article. The data to be discussed consist chiefly of admissions to and visits for antepartum and postpartum medical and nursing services, visits for home-delivery nursing service, admissions and visits to medical and nursing services for infants and for preschool and school children, and dental inspections of preschool and school children. Services reported for the calendar year 1940 are covered in this report.

These services are provided by physicians, nurses, and dental staffs working in county or district health departments or in unorganized areas which are under the jurisdiction of the State health agency. It should be constantly borne in mind, that nowhere in this article do the figures quoted represent the total resources for medical and nursing care available for mothers and children. In addition to care paid for entirely by the patient, there are private agencies and public agencies other than the health departments which also have important contributions to make to the

health care of the population. The data discussed here are only those recorded by the State health departments. The local areas report activities of their personnel according to the definitions and conventions of the Tabulation of Health Department Services, 2/ and in each State health department office these local reports are consolidated and sent to the Children's Bureau as quarterly reports for the State.

Although the reporting procedure is limited to activities administered or supervised by the State health agency, differing interpretations and uses of this phrase are responsible for many inequalities from State to State. Because of actual differences either in the laws or in voluntary agreements, some State health departments include as under their jurisdiction health services in cities, and other State agencies have no supervision in the cities. Probably the most common pattern is that in which the larger cities have separate and independent health departments while the rest of the urban areas, including the smaller cities, and some of the rural parts of the State, are served by local organizations supervised by the State health department. The relation of the

1/ As used in this article the term "States" includes the District of Columbia, Alaska, Hawaii, and Puerto Rico.

2/ Tabulation of Health Department Services. Reprint 1768 from Public Health Reports, Vol. 51, No. 36 (Sept. 4, 1936).

State official health agency to other official agencies, to voluntary agencies, and to local personnel varies very widely from State to State as well as from one part of a State to another. Moreover, services are not uniformly provided or reported in areas which are under the jurisdiction of the State health department.

In other words, these data do not present complete records of the care of mothers and children provided by State health departments, much less that provided by other agencies. Because the data from each State are composed of reports made by many individuals, they show all the variability inherent in this method of obtaining data.

The basic units of count in these State reports are "admissions to service" and "visits." By agreement of the State and Territorial Health Officers, the United States Public Health Service, and the United States Children's Bureau, certain definitions for various counts of service were adopted in 1936. ^{3/} According to this agreement the counts are made on a calendar-year basis, so that the first visit during a calendar year is counted as an admission and a visit, and the admissions represent persons served per year.

If the admissions to service are counted in this way, there should be, of course, at least as many visits as admissions and more admissions in the first quarter of the calendar year than in the later quarters for all services where repeated visits are made. Study of the quarterly figures

shows, however, that many States apparently have not interpreted the instructions correctly. In the records of only 22 States were the admissions for the first quarter sufficiently larger than subsequent quarters to fulfill these requirements. That is, 30 States apparently did not follow the conventional definition of admissions.

The "admissions" according to the definition stated above, represent the number of persons given a particular kind of care during the calendar year. The count of visits gives the number of times during the year that such care was given to those persons. The ratio of visits to admissions will then give the average number of services of a particular kind per person per year. Of more interest for types of care continuing over a limited period would be some method of measuring the amount of service provided per person for the entire time covered by the particular service, regardless of the convention imposed by calendar years. The ratio of visits to admissions would be a method of approximating this measure, but this ratio will always underestimate the number of visits per case on a particular service. According to the definition of admissions all cases receiving service during a calendar year are counted. However, not all visits to these cases are counted since there would be a number of visits given in the preceding year to the carry-over cases, and a similar number of visits in the following year to cases which will be carried over to that year. Consequently, the average number of visits per case will be higher than the average number of visits per admissions.

^{3/} Id.

The quarterly reports received by the Children's Bureau do afford material for estimating the correct number of visits per case. The way in which this may be accomplished for antepartum medical service is shown by the following illustration, based on data for 1939 and 1940. The apparent number of cases "carried over" may be taken as the excess of the number of admissions in the first quarter over the average of the admissions for the last quarter in the previous year and the second quarter of the current year. This is shown in table 1. All the States that did not report more admissions in the first quarter of 1940 than in later quarters were

excluded, since they apparently have misinterpreted the instructions. This calculation of the "carry-overs" is, therefore, based on records from 22 States.

This table shows for these 22 States that there probably were approximately 6,943 individuals who were admitted to antepartum medical service for the first time in 1939 but whose care was not completed during that year and who were readmitted during 1940. The total number of admissions reported in 1940 was 64,711. With the 6,943 carry-overs deducted the number of new cases admitted to antepartum service was 57,768.

Table 1.--Antepartum medical service in 22 States, 1940

State	Admissions				New cases (estimated)	1940 total visits	Visits per admission	Visits per case (estimated)
	First quarter 1940	Average fourth quarter 1939 second quarter 1940	Excess of first quarter over average	1940 total				
22 States.....	20,328	13,405	6,923	64,711	57,788	221,332	3.4	3.8
Alabama.....	2,517	1,646	871	8,600	7,729	26,393	3.1	3.4
Alaska.....	28	4	24	48	24	158	3.3	6.6
Arizona.....	364	226	138	1,227	1,089	3,913	3.2	3.6
Colorado.....	211	158	53	707	654	2,341	3.3	3.6
Delaware.....	50	28	22	182	160	414	2.7	2.6
District of Columbia....	1,841	1,011	830	5,108	4,278	23,257	4.6	5.4
Georgia.....	4,641	3,638	1,003	16,595	15,592	52,798	3.2	3.4
Hawaii.....	1,041	533	508	2,635	2,127	9,695	3.7	4.6
Kansas.....	294	184	110	757	647	3,800	5.0	5.9
Kentucky.....	2,939	1,732	1,207	9,223	8,016	28,404	3.1	3.5
Louisiana.....	506	307	199	1,677	1,478	5,995	3.6	4.1
Maryland.....	791	531	260	2,473	2,213	5,026	2.0	2.3
Minnesota.....	156	112	44	447	403	1,647	3.7	4.1
Missouri.....	458	218	240	1,269	1,029	3,808	3.0	3.7
New Hampshire.....	16	15	1	44	43	98	2.2	2.3
New York.....	2,671	1,793	878	7,684	6,806	35,182	4.6	5.2
Oklahoma.....	279	198	81	960	879	2,035	2.1	2.3
Oregon.....	82	51	31	214	183	653	3.1	3.6
South Dakota.....	31	27	4	93	89	257	2.8	2.9
Texas.....	871	608	263	2,855	2,592	11,083	3.9	4.3
Utah.....	165	87	78	583	505	1,478	2.5	2.9
West Virginia.....	376	298	78	1,330	1,252	2,897	2.2	2.3

The total number of visits reported for the 22 States was 221,332. Among these visits there were some given to the 6,923 cases carried over from 1939. But there will be a similar number of women at the end of 1940 who will receive a corresponding number of visits in 1941. Consequently, the ratio of total visits (221,332) to total new cases (57,788) gives the approximate number of visits per case. This figure, 3.8, is 12 percent higher than the 3.4 which represents the number of visits per admission.

This discussion has indicated the use of the counts reported as a measure of the amount of service provided per case. Obviously, one would also like to know how many of the people who needed health care actually got it through the State health departments. There is no way of knowing this exactly. Actually one would wish to know the total number of pregnant women who because of financial or other reasons are not able to provide care for themselves. These data are not available but if one assumes that a certain proportion of all pregnant women fall into the category of requiring care from public-health agencies, then the resident births may be used as an approximation to the population wanted. These birth data have other shortcomings, since they do not include pregnancies that terminate in abortions or stillbirths. In view of the lack of more exact statistics, the ratio of admissions to resident births, admittedly crude as it is, nevertheless is the best available measure of the extent of service.

If the ratio of admissions to total resident births is used, the figure obtained will be too

small an index of extent of service because care given in parts of States (especially the larger cities) will not be represented in the count of admissions whereas the count of births is complete for each State. 4/

If, on the other hand, the ratio of admissions to rural residents births is used, the index obtained will be too high since services in some urban areas will be included in the service counts but the births for these areas are excluded. The true proportion of the population needing care that actually received it under the supervision of the State health departments lies somewhere between these limits.

The actual counts of service reported are given for the individual States in the appendix tables. The discussion which follows is based on them.

Antepartum Medical Service.

Of the 52 States reporting to the Children's Bureau, 4 (Connecticut, Massachusetts, North Dakota, and Vermont) did not provide antepartum medical service under the jurisdiction of the State health departments. The other 48 reported a total of 146,252 persons given this service during the calendar year 1940.

If the ratio of admissions to resident births is used to measure the extent of the services provided, it is necessary to deduct from this count

4/ The figures used for resident births are for the year 1938, which are the latest figures available. Vital Statistics of the United States, 1938, pt.II. The figures for individual States vary so little from year to year that no gross error is introduced by using births for a year different from that for which activities are reported.

of admissions those reported from the Territories of Alaska, Hawaii, and Puerto Rico, because the data on resident births are not available for these areas. The total admissions from the remaining 45 States were 127,894, the total resident births 2,182,684, and the rural resident births 1,270,607. The resulting ratios indicate that between 6 and 10 per cent of the potential patients were given care by agencies supervised by the State Health Departments of the several States.

The 48 States that provided antepartum-medical-conference service reported 434,262 visits for the year 1940. This is an average of 3.0 visits per admission per year. If the correction factor for service per person is considered to apply to all States, it seems probable that the ratio of 3.0 visits per admission would be about 12 percent too low and that the average number of visits per expectant mother to the health-department conferences would be about 3.4.

The individual States varied widely in the extent to which they furnished antepartum medical care to those who need it. It will be seen from table 2 and chart 1 that the District of Columbia recorded service in 1940 to a number equal to almost half of the expectant mothers residing there. In slightly more than one-fifth of the States the number of expectant mothers receiving medical service was equal to at least 10 per cent of the resident births.

When the births occurring to women in the rural areas of the States are used as the measure of the extent of service instead of the births to residents of the entire State, the more urban States

show the greater differences, as would be expected. Several of the predominantly rural States show very little change between the two ratios.

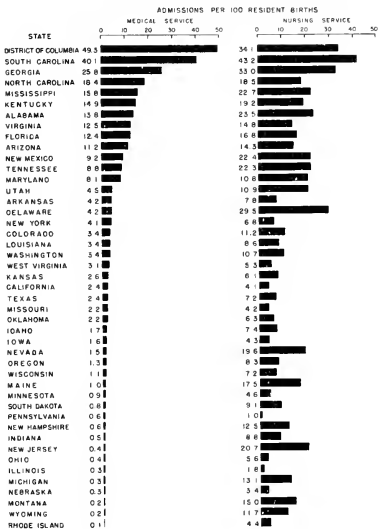
Table 2.--Extent of antepartum medical service in 45 States, 1940

State	Admissions per 100 total resident births ^a	Admissions per 100 rural resident births ^a
45 States.....	5.9	10.1
Alabama.....	13.8	17.5
Arizona.....	11.2	16.3
Arkansas.....	4.2	4.8
California.....	2.4	5.8
Colorado.....	3.4	5.8
Delaware.....	4.2	7.3
District of Columbia.....	49.3	.....
Florida.....	12.4	19.3
Georgia.....	25.8	33.5
Idaho.....	1.7	1.9
Illinois.....	0.3	1.0
Indiana.....	0.5	0.9
Iowa.....	1.6	2.3
Kansas.....	2.6	3.8
Kentucky.....	14.9	18.3
Louisiana.....	3.4	4.7
Maine.....	1.0	1.3
Maryland.....	8.1	16.7
Michigan.....	0.3	0.8
Minnesota.....	0.9	1.4
Mississippi.....	15.8	17.5
Missouri.....	2.2	3.7
Montana.....	0.2	0.3
Nebraska.....	0.3	0.4
Nevada.....	1.5	1.8
New Hampshire.....	0.6	1.1
New Jersey.....	0.4	1.3
New Mexico.....	9.2	10.8
New York.....	4.1	17.5
North Carolina.....	18.4	21.9
Ohio.....	0.4	0.9
Oklahoma.....	2.2	2.9
Oregon.....	1.3	2.0
Pennsylvania.....	0.6	1.3
Rhode Island.....	0.1	0.5
South Carolina.....	40.1	46.5
South Dakota.....	0.8	0.9
Tennessee.....	8.8	11.9
Texas.....	2.4	3.5
Utah.....	4.5	6.8
Virginia.....	12.5	15.7
Washington.....	3.4	6.4
West Virginia.....	3.1	3.8
Wisconsin.....	1.1	2.0
Wyoming.....	0.2	0.2

^a Data for resident births are for 1938.

The largest number of visits per admission (5 or more) was reported in Michigan, Nebraska, Kansas, and Montana. If the correction factor already discussed is applied, these States record

Chart 1—NUMBER OF ADMISSIONS TO ANTEPARTUM MEDICAL AND NURSING SERVICES DURING 1940 PER 100 RESIDENT BIRTHS DURING 1938 IN 45 STATES



from 5.6 to more than 6 visits per person during the antepartum period. Wisconsin and Wyoming appeared to provide the smallest number—1.2 visits per admission or 1.3 visits per case. The ratios per admission are given for individual States in appendix table A.

Postpartum Medical Services.

There are 45 States that report medical examinations for postpartum patients. The total number of women so examined was 34,702. This service

represents a single examination for each person.

It is of interest, however, to compare the number of postpartum cases with the number of admissions to antepartum medical care. There are 44 States that reported both postpartum and antepartum services. They reported 144,958 admissions to antepartum medical service and 34,690 postpartum medical examinations given. That is, postpartum examinations were given to only about a quarter as many women as were admitted to antepartum service.

This does not necessarily mean that all the postpartum cases examined had previously been given antepartum service during the calendar year. For example, Indiana and Montana reported more postpartum examinations than admissions to antepartum service. The percentages varied from 106 for Indiana to 2.3 for South Carolina. Sixteen States reported that more than half as many women were given postpartum medical examinations as were given antepartum care during 1940. Appendix table A shows the data for the individual States.

Antepartum Nursing Service.

All 52 States reported antepartum nursing service. A total of 257,900 individuals were given care during 1940. The admissions to this health service for the 49 States for which figures for resident births are available totaled 238,878, or an average of 10.5 percent of all the births were given nursing care before delivery. This same number of admissions represents 18.3 percent of the rural resident births. So that it may be fair to assume that health department nursing service was used by from 10 to 18 percent of the individuals who might be in need of this type of care.

The 52 States reported 722,831 visits for antepartum nursing service or an average of 2.8 visits per admission. If the same line of argument presented in the introduction is followed but data for antepartum nursing are used, visits per admission to nursing service are shown to underestimate

the number of visits per woman cared for during the antepartum period by about 10 percent (table 3). For the 36 States where the quarterly counts of admissions follow the accepted pattern, the ratio of visits per admission was 3.0 and of visits per case, 3.3. The ratio of 2.8 visits per admission

Table 3.--Antepartum nursing service in 36 States, 1940

State	Admissions			1940 total	New cases (estimated)	1940 total visits	Visits per admission	Visits per case (estimated)
	First quarter 1940	Average fourth quarter 1939 second quarter 1940	Excess of first quarter over average					
36 States.....	51,113	34,966	16,147	158,883	142,736	475,800	3.0	3.3
Alabama.....	4,673	3,375	1,298	14,602	13,304	36,148	2.5	2.7
Alaska.....	117	63	54	332	278	939	2.8	3.4
Arizona.....	403	322	81	1,569	1,488	5,637	3.6	3.8
Arkansas.....	858	660	198	2,916	2,718	6,955	2.4	2.6
California.....	1,255	1,010	245	4,226	3,981	11,446	2.7	2.9
Colorado.....	834	506	328	2,293	1,965	7,373	3.2	3.8
Connecticut.....	188	117	71	501	430	1,312	2.6	3.1
Delaware.....	369	268	101	1,290	1,189	2,819	2.2	2.4
District of Columbia....	1,227	741	486	3,534	3,048	15,221	4.3	5.0
Florida.....	1,513	1,126	387	5,228	4,841	13,526	2.6	2.8
Georgia.....	6,123	4,528	1,595	21,216	19,621	77,098	3.6	3.9
Hawaii.....	1,104	571	533	2,918	2,385	9,944	3.4	4.2
Idaho.....	271	240	31	842	811	2,779	3.3	3.4
Iowa.....	758	505	253	2,402	2,149	7,413	3.1	3.4
Kentucky.....	3,456	2,602	854	11,876	11,022	29,216	2.5	2.7
Louisiana.....	1,335	937	398	4,205	3,807	11,299	2.7	3.0
Maine.....	910	636	274	2,670	2,396	5,025	1.9	2.1
Maryland.....	1,145	793	352	3,295	2,943	8,791	2.7	3.0
Minnesota.....	720	545	175	2,286	2,111	4,852	2.1	2.3
Mississippi.....	3,721	2,662	1,059	12,221	11,162	28,862	2.4	2.6
Montana.....	482	305	177	1,611	1,434	3,695	2.3	2.6
Nebraska.....	206	175	31	754	723	1,885	2.5	2.6
Nevada.....	125	80	45	381	336	1,079	2.8	3.2
New Hampshire.....	357	206	151	962	811	3,662	3.8	4.5
New Jersey.....	5,101	2,128	2,973	11,806	8,833	49,613	4.2	5.6
New Mexico.....	984	725	259	3,202	2,943	7,524	2.3	2.6
New York.....	4,434	2,732	1,702	12,946	11,244	52,802	4.1	4.7
North Carolina.....	4,639	3,580	1,059	14,795	13,736	41,351	2.8	3.0
North Dakota.....	443	354	89	1,233	1,144	2,796	2.3	2.4
Oklahoma.....	848	595	253	2,781	2,528	6,773	2.4	2.7
Oregon.....	423	274	149	1,336	1,187	3,547	2.7	3.0
Rhode Island.....	151	105	46	463	417	932	2.0	2.2
South Dakota.....	291	276	15	1,090	1,075	3,194	2.9	3.0
Vermont.....	164	102	62	528	466	1,619	3.1	3.5
Wisconsin.....	1,247	968	279	3,982	3,703	7,433	1.9	2.0
Wyoming.....	238	154	84	591	507	1,240	2.1	2.4

for the 52 States probably means therefore about 3.1 nursing visits for each expectant mother cared for.

The reports indicate that South Carolina gave antepartum nursing service to a larger proportion of pregnant women than did any other State and that Massachusetts gave this service to the lowest proportion. These ratios are shown in table 4 and on chart 1 which also shows similar data for medical service.

This chart shows some interesting relations between the medical and nursing services furnished during the antepartum period. Some States, such as the District of Columbia, South Carolina, and Georgia, actually gave both services to a comparatively large proportion of the pregnant women. In other States such as Delaware, Indiana, and New Jersey, the relatively small amount of medical care was somewhat compensated for by a more than average extensive nursing service. And, of course, other States were low in both types of prenatal care provided through State health departments.

The States showed somewhat less variation in the amount of nursing service per admission than was shown for the corresponding medical service. The range of visits per admission for the antepartum nursing service was from 4.3 for the District of Columbia to 1.7 for South Carolina. There were 7 States that gave approximately 4.0 visits per admission and, therefore, nearly 4.5 visits per case. Seven States recorded 2 or less visits per admission.

The ratios per admission are shown in appendix table A.

Nursing Service at Delivery.

Home-delivery-nursing service was reported

Table 4.--Extent of antepartum nursing service in 49 States, 1940

State	Admissions per 100 total resident births ^a	Admissions per 100 rural resident births ^a
49 States.....	10.5	18.3
Alabama.....	23.5	29.7
Arizona.....	14.3	20.9
Arkansas.....	7.8	8.9
California.....	4.1	10.1
Colorado.....	11.2	18.7
Connecticut.....	2.1	6.2
Delaware.....	29.5	51.6
District of Columbia.....	34.1	.....
Florida.....	16.8	26.2
Georgia.....	33.0	42.8
Idaho.....	7.4	8.2
Illinois.....	1.8	5.0
Indiana.....	8.8	18.6
Iowa.....	4.3	6.1
Kansas.....	8.1	12.0
Kentucky.....	19.2	23.6
Louisiana.....	8.6	11.8
Maine.....	17.5	23.8
Maryland.....	10.8	22.2
Massachusetts.....	0.2	1.2
Michigan.....	13.1	30.6
Minnesota.....	4.6	7.1
Mississippi.....	22.7	25.1
Missouri.....	4.2	7.0
Montana.....	15.0	20.1
Nebraska.....	3.4	4.7
Nevada.....	19.6	23.8
New Hampshire.....	12.5	23.9
New Jersey.....	20.7	62.3
New Mexico.....	22.4	26.2
New York.....	6.8	29.4
North Carolina.....	18.5	22.1
North Dakota.....	9.6	11.1
Ohio.....	3.6	8.4
Oklahoma.....	6.3	8.3
Oregon.....	8.3	12.7
Pennsylvania.....	1.0	2.0
Rhode Island.....	4.4	32.5
South Carolina.....	43.2	50.1
South Dakota.....	9.1	10.8
Tennessee.....	22.3	30.0
Texas.....	7.2	10.8
Utah.....	10.9	16.4
Vermont.....	8.2	9.7
Virginia.....	14.8	18.6
Washington.....	10.7	19.8
West Virginia.....	5.3	6.4
Wisconsin.....	7.2	12.5
Wyoming.....	11.7	14.1

^aData for resident births are for 1938.

given to 18,319 women in 47 States. The number of women delivered elsewhere than in hospitals may be used to measure the size of the problem since they will all need some kind of home nursing care. Therefore the number of births occurring at home was related to the number of women given home-delivery-nursing service. These data are not available for all 47 of the States that report home-delivery-nursing service. But there are 45 States for which both cases and home deliveries are available. In these 45 States of 1,021,205 women delivered at home, 18,287 women (1.8 percent) were given nursing service by health departments. If the home deliveries in rural areas are used as the measure of the extent of the problem, then 2.2 percent of the 830,146 home deliveries in rural areas received nursing service through the State health departments.

The States varied in the percentage of women delivered at home who received nursing service from 13.4 percent in New Jersey, to 0.1 percent in Arkansas, Missouri, Texas, and Wisconsin. Half the States provided this type of care to 1.5 percent or more of the women delivered at home. These ratios are shown in table 5.

Postpartum Nursing Service.

Since New Jersey was the only State that does not report this type of care under health department jurisdiction, there were 51 reporting areas which recorded a total of 190,434 women given such care during 1940. When these admissions are related to the admissions to antepartum nursing service for the same States (246,094), a ratio of 77.4 percent is obtained.

The postpartum nursing service, unlike the postpartum medical service, continues over a period of time, defined in the Tabulation of Health Department Services as 6 weeks. Therefore, the added

Table 5.--Extent of home-delivery-nursing service in 45 States, 1940

State	Cases per 100 total home deliveries ^a	Cases per 100 rural home deliveries ^a
45 States.....	1.8	2.2
Alabama.....	0.9	1.0
Arizona.....	2.7	3.3
Arkansas.....	0.1	0.1
California.....	4.8	8.3
Colorado.....	9.5	12.3
Connecticut.....	1.7	4.2
Florida.....	0.6	0.8
Georgia.....	0.8	0.9
Idaho.....	4.8	4.9
Illinois.....	1.7	2.5
Indiana.....	4.0	5.8
Iowa.....	1.1	1.3
Kansas.....	3.1	3.9
Kentucky.....	4.9	5.4
Louisiana.....	0.5	0.5
Maine.....	0.9	1.0
Maryland.....	2.5	3.8
Massachusetts.....	0.8	3.3
Michigan.....	1.9	3.2
Minnesota.....	0.7	0.8
Mississippi.....	0.6	0.7
Missouri.....	0.1	0.1
Montana.....	4.6	4.8
Nebraska.....	0.8	0.9
Nevada.....	7.5	7.9
New Hampshire.....	2.3	3.8
New Jersey.....	13.4	28.6
New Mexico.....	0.4	0.4
New York.....	5.9	11.4
North Carolina.....	0.7	0.8
North Dakota.....	0.6	0.7
Ohio.....	0.7	1.0
Oklahoma.....	0.9	1.1
Oregon.....	1.5	1.6
South Carolina.....	0.6	0.6
South Dakota.....	3.1	3.4
Tennessee.....	4.3	4.9
Texas.....	0.1	0.1
Utah.....	1.5	1.7
Vermont.....	8.5	9.4
Virginia.....	2.3	2.6
Washington.....	1.6	2.1
West Virginia.....	0.4	0.5
Wisconsin.....	0.1	0.1
Wyoming.....	1.0	1.1

^a Data for home deliveries are for 1939.

count of number of visits is available for this service. The 51 reporting areas showed a total of 478,086 visits or an average of 2.5 visits per admission.

The variation from State to State in the proportion of the antepartum cases that received postpartum nursing care is extreme.

These ratios are shown in appendix table A. Six States apparently gave more postpartum than antepartum nursing care. In 6 States the number of women who received postpartum care was 90 to 100 percent of the number admitted to antepartum care. Only 3 States, Puerto Rico, Nevada, and South Carolina, reported postpartum care for less than half the number of antepartum admissions.

The average number of visits made by the nurses to each woman admitted during the year varies from 7.9 in Kansas to 1.0 in Rhode Island. About half the States provide more than 2.4 visits per admission during the year (see appendix table A).

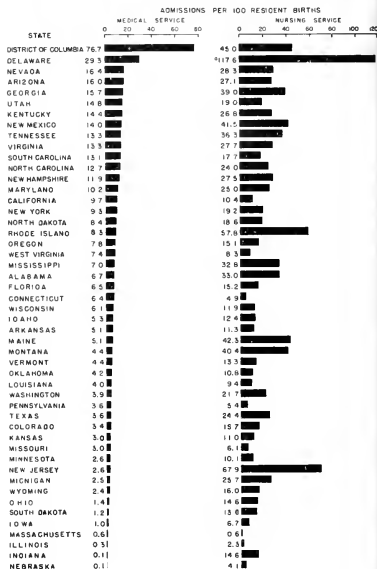
Infant Medical Service.

All 52 States reported infant medical services for 1940 to 174,840 individuals. For the 49 areas for which resident births are available, there were 147,850 admissions. If the total resident births (2,286,962) and the rural resident births (1,307,406) are again used to indicate the limits of the problem, the reports indicate that about 6.5 percent of the total births and 11.3 percent of the rural births did get infant medical supervision by the health departments.

There were 515,285 visits reported to these 174,840 individuals or an average of 2.9 visits per admission per year.

The States showed a range in the ratio of admissions for medical service to resident births of from 76.7 percent for the District of Columbia to 0.1 for Indiana and Nebraska. There were 14 States that reported infant medical services for 10 per-

Chart 2.—NUMBER OF ADMISSIONS TO INFANT MEDICAL AND NURSING SERVICES DURING 1940 PER 100 RESIDENT BIRTHS DURING 1938 IN 49 STATES



APPARENT ERROR

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cent or more of the total resident births. These ratios are shown in table 6 and chart 2.

Table 6.--Extent of infant medical service in 49 States, 1940

State	Admissions per 100 total resident births ^a	Admissions per 100 rural resident births ^a
49 States.....	6.5	11.3
Alabama.....	6.7	8.5
Arizona.....	16.0	23.2
Arkansas.....	5.1	5.7
California.....	9.7	23.8
Colorado.....	3.4	5.6
Connecticut.....	6.4	18.9
Delaware.....	29.3	51.3
District of Columbia.....	76.7	.....
Florida.....	6.5	10.1
Georgia.....	15.7	20.3
Idaho.....	5.3	5.8
Illinois.....	0.3	1.0
Indiana.....	0.1	0.2
Iowa.....	1.0	1.4
Kansas.....	3.0	4.4
Kentucky.....	14.4	17.8
Louisiana.....	4.0	5.5
Maine.....	5.1	6.9
Maryland.....	10.2	21.0
Massachusetts.....	0.6	2.8
Michigan.....	2.5	5.9
Minnesota.....	2.6	4.1
Mississippi.....	7.0	7.7
Missouri.....	3.0	5.1
Montana.....	4.4	6.0
Nebraska.....	0.1	0.2
Nevada.....	16.4	19.9
New Hampshire.....	11.9	22.7
New Jersey.....	2.6	7.9
New Mexico.....	14.0	16.4
New York.....	9.3	39.9
North Carolina.....	12.7	15.1
North Dakota.....	8.4	9.7
Ohio.....	1.4	3.2
Oklahoma.....	4.2	5.5
Oregon.....	7.8	12.0
Pennsylvania.....	3.6	7.5
Rhode Island.....	8.3	61.3
South Carolina.....	13.1	15.2
South Dakota.....	1.2	1.4
Tennessee.....	13.3	17.9
Texas.....	3.6	5.4
Utah.....	14.8	22.4
Vermont.....	4.4	5.2
Virginia.....	13.3	16.7
Washington.....	3.9	7.1
West Virginia.....	7.4	9.0
Wisconsin.....	6.1	10.5
Wyoming.....	2.4	2.8

The ratio of admissions to visits for the 52 States varied from 6.0 visits per admission in Pennsylvania to 1 visit per admission in Maine, Massachusetts, and North Dakota. Thirteen States provided 3 or more visits per child during the year. Appendix table B shows the ratios for each State.

Preschool Medical Service.

This service was reported from 51 States with a total volume of 298,781 individuals admitted for the year. Services for the preschool child, according to the definitions in the Tabulation of Health Department Services, extend from the time the child is 1 year old until he is 6 years of age. Data from the 1940 census are not yet available by single years of age, so that no exact population base for this age group can be determined. As an approximation, however, the population under 5 years of age has been used to indicate the theoretical extent of the problem. This age group of the population is not available for Alaska, Hawaii, and Puerto Rico, but for the remaining States there were 10,493,589 children under 5 years of age. Thus, the admissions reported for these States (279,660) represent 2.7 percent of the population of children under 5 years of age.

There were 573,825 visits to preschool conferences reported from the 51 States giving a ratio of 1.9 visits per admission per year.

For the 48 States for which both admissions and population under 5 years are available, the extent of the preschool medical service varied from 215.5 (District of Columbia) to 1.8 (Iowa) ad-

^a Data for resident births are for 1938.

missions for each 1,000 of the population under 5 years. These data are shown in table 7.

Table 7.--Extent of preschool medical service in 48 States, 1940

State	Admissions per 1,000 1940 population under 5 years of age
48 States.....	26.7
Alabama.....	37.6
Arizona.....	22.6
Arkansas.....	28.3
California.....	34.1
Colorado.....	13.6
Connecticut.....	39.3
Delaware.....	121.9
District of Columbia.....	215.5
Florida.....	18.2
Georgia.....	42.4
Idaho.....	38.4
Illinois.....	2.2
Indiana.....	5.3
Iowa.....	1.8
Kansas.....	27.8
Kentucky.....	53.9
Louisiana.....	14.8
Maine.....	46.5
Maryland.....	77.3
Massachusetts.....	9.7
Michigan.....	20.4
Minnesota.....	12.4
Mississippi.....	39.3
Missouri.....	7.3
Montana.....	29.0
Nevada.....	71.5
New Hampshire.....	74.0
New Jersey.....	2.4
New Mexico.....	68.0
New York.....	21.8
North Carolina.....	61.1
North Dakota.....	97.1
Ohio.....	10.1
Oklahoma.....	26.3
Oregon.....	40.9
Pennsylvania.....	3.5
Rhode Island.....	5.2
South Carolina.....	29.7
South Dakota.....	9.0
Tennessee.....	58.3
Texas.....	10.4
Utah.....	64.7
Vermont.....	49.0
Virginia.....	46.4
Washington.....	30.1
West Virginia.....	69.3
Wisconsin.....	34.0
Wyoming.....	6.4

The visits per admission varied from 10.9 reported from Pennsylvania to 1.0 from Maine, Massachusetts, and North Dakota. Twenty-three States reported 2 or more visits per child per year. Appendix table B shows these averages for each State.

Dental Inspections.

For the 46 States reporting dental inspections of preschool children, a total of 64,721 inspections was reported. Inspections for school children were reported from 48 States, totaling 1,160,372 inspections. There is a decided lack of uniformity in the understanding of what constitutes a dental inspection, with the result that the figures reported by the States seem too unreliable to use in calculating any index or ratio. The inspections reported from each State are, however, included in appendix table B.

Infant Nursing Service.

A total of 449,798 admissions to this service was recorded from the 52 reporting areas. For the 49 areas for which resident birth data are available 430,204 admissions were reported. Again with the total resident births and the resident births from rural areas as the upper and lower limits of the problem, ratios of 18.8 percent and 32.9 percent respectively are obtained. That is, health department nurses actually saw during 1940 about 20 percent of the infants.

There were 1,452,049 visits for infant nursing service reported from all the areas. This gives a crude ratio of 3.2 visits per admission.

The individual States, of course, show extreme variations in the extent to which the infant

nursing service by the health departments may be said to meet the problem if this is measured by the number of births. Chart 2 and table 8 show these extremes. Except for Delaware ⁵/ the highest ratio of admissions to resident births was in New Jersey and the lowest, in Massachusetts. Chart 2 also shows how the nursing service supplements, and in some States complements, the medical service for infants. For example, New Jersey reported infant medical service to only 2.6 percent of the births, but the nursing service reached 67.9 percent of the births.

The ratio of visits per admission showed somewhat less extreme variation for this service than for many others. New Jersey reported the most intensive service, 5.9 visits for each infant admitted during the year. There were two other areas, Alaska and Puerto Rico that reported over 5 visits per admission per year. Wisconsin reported the lowest ratio, 1.9 visits per admission. Approximately half the States reported three or more visits during the year for each admission.

The ratios are given for each State in appendix table B.

Preschool Nursing Service.

The 52 States reported a total of 523,582 individuals admitted to preschool nursing service. For the 49 States for which the population under 5 years of age is available, there were 504,728 admissions to service or a ratio of 4.8 percent of the approximate population involved.

There were 1,226,628 visits for preschool

Table 8.--Extent of infant nursing service in 49 States, 1940

State	Admissions per 100 total resident births ¹	Admissions per 100 rural resident births ¹
49 States.....	18.8	32.9
Alabama.....	33.0	41.7
Arizona.....	27.1	39.5
Arkansas.....	11.3	12.8
California.....	10.4	25.4
Colorado.....	15.7	26.3
Connecticut.....	4.9	14.4
Delaware.....	117.6	205.8
District of Columbia.....	45.0	.....
Florida.....	15.2	23.6
Georgia.....	39.0	50.7
Idaho.....	12.4	13.6
Illinois.....	2.3	6.2
Indiana.....	14.6	27.4
Iowa.....	6.7	9.5
Kansas.....	11.0	16.3
Kentucky.....	26.8	33.0
Louisiana.....	9.4	12.9
Maine.....	42.3	57.6
Maryland.....	25.0	51.4
Massachusetts.....	0.6	2.8
Michigan.....	25.7	60.3
Minnesota.....	10.1	15.8
Mississippi.....	32.8	36.3
Missouri.....	6.1	10.2
Montana.....	40.4	54.3
Nebraska.....	4.1	5.6
Nevada.....	28.3	34.4
New Hampshire.....	27.5	52.4
New Jersey.....	67.9	204.3
New Mexico.....	41.5	48.6
New York.....	19.2	82.4
North Carolina.....	24.0	28.6
North Dakota.....	18.6	21.5
Ohio.....	14.6	34.4
Oklahoma.....	10.8	14.3
Oregon.....	15.1	23.0
Pennsylvania.....	5.4	11.1
Rhode Island.....	57.8	425.0
South Carolina.....	17.7	22.5
South Dakota.....	13.8	16.4
Tennessee.....	36.3	49.0
Texas.....	24.4	36.5
Utah.....	19.0	28.7
Vermont.....	13.3	15.7
Virginia.....	27.7	35.0
Washington.....	21.7	40.0
West Virginia.....	8.3	10.0
Wisconsin.....	11.9	20.6
Wyoming.....	16.0	19.3

¹ Data for resident births are for 1938.
nursing service reported which gives a ratio of 2.3 visits per admission.

⁵/ The rate for Delaware (117.6) indicates an apparent error in reporting admissions.

Table 9.--Extent of preschool nursing service in 49 States, 1940

State	Admissions per 1,000 1940 population under 5 years of age
49 States.....	47.6
Alabama.....	52.1
Arizona.....	39.5
Arkansas.....	35.7
California.....	21.4
Colorado.....	36.9
Connecticut.....	28.1
Delaware.....	169.6
District of Columbia....	90.7
Florida.....	36.2
Georgia.....	73.3
Idaho.....	27.4
Illinois.....	1.5
Indiana.....	33.2
Iowa.....	11.0
Kansas.....	18.0
Kentucky.....	88.1
Louisiana.....	19.6
Maine.....	178.2
Maryland.....	43.4
Massachusetts.....	3.2
Michigan.....	76.0
Minnesota.....	27.0
Mississippi.....	143.7
Missouri.....	9.9
Montana.....	123.3
Nebraska.....	8.6
Nevada.....	81.2
New Hampshire.....	84.6
New Jersey.....	284.0
New Mexico.....	135.5
New York.....	51.6
North Carolina.....	42.8
North Dakota.....	56.2
Ohio.....	29.2
Oklahoma.....	44.5
Oregon.....	49.6
Pennsylvania.....	3.4
Rhode Island.....	273.7
South Carolina.....	33.6
South Dakota.....	38.0
Tennessee.....	109.9
Texas.....	32.4
Utah.....	26.9
Vermont.....	61.8
Virginia.....	32.0
Washington.....	35.5
West Virginia.....	23.2
Wisconsin.....	33.3
Wyoming.....	22.5

Table 9 shows the individual State's ratios of admissions to population under 5 years of age. The most extensive service was reported by New Jersey with a rate of 284 admissions to nursing service per 1,000 children under 5 years of age. Rhode Island reported 274 admissions per 1,000 children under 5 years and 6 additional States reported rates of more than 100. At the other extreme there are 5 States which showed less than 10 children admitted per 1,000 of the age group under 5 years.

The preschool nursing service provided by the health departments shows even less variation than did the infant nursing service in the number of visits per child served. Utah recorded 4.8 visits for each preschool child admitted and Iowa and Mississippi, 1.5. Approximately half the States reported more than 2.3 visits per admission and 12 States, less than 2.0 visits per admission. These ratios are shown in appendix table B.

Services for School Children.

There were 1,608,968 examinations of school children by physicians reported from 47 States. Nursing service to the extent of 1,526,229 visits were made to school children in 51 States.

The administration of the health department's services to school children varies so widely among the States that there is no effective population base on which to measure the service provided. The examinations of school children reported are shown in appendix table B.

APPENDIX TABLE A
MATERNITY SERVICE, CALENDAR YEAR 1940

State	Medical service					Nursing service				
	Antenatal		Postpartum			Antenatal		Postpartum		
	Cases admitted	Visits	Average per admission	Cases examined	Number of cases per hundred ante-partum admissions	Cases admitted	Visits	Average per admission	Cases given nursing service at delivery	Number of cases per hundred ante-partum admissions
	Total					Total				
	(D 1)	(D 3)		(D 8)		(D 2)	(D 5, 6)		(D 7)	(D 10)
Total	186,252	534,262	3.0	34,702		257,900	722,831	2.8	18,319	190,434
Northwestern region:										
Connecticut.....	0	0	0	0		901	1,312	2.6	47	393
Delaware.....	146	* 667	4.6	133	91.1	2,670	5,085	1.9	76	2,110
Massachusetts.....	0	0	0	0		* 134	484	3.4	97	119
New Hampshire.....	44	98	2.2	42	95.5	962	1,662	1.8	54	895
New Jersey.....	256	710	2.8	0		11,806	46,613	4.2	1,462	0
New York.....	7,624	35,182	4.6	4,111	53.5	12,946	52,602	4.1	1,685	12,334
Pennsylvania.....	* 1,021	4,736	4.6	(b)		* 1,578	5,683	3.6	(b)	
Rhode Island.....	* 7	19	2.7	0		463	932	2.0	0	267
Vermont.....	0	0	0	12		* 588	1,619	3.1	267	423
North Central region:										
Illinois.....	* 431	* 791	1.8	* 307	71.2	* 2,221	4,601	2.1	596	1,757
Indiana.....	* 278	568	2.1	* 296	106.5	* 5,274	13,928	2.6	* 1,234	* 8,100
Iowa.....	* 651	1,902	2.8	* 33	48.5	1,604	3,567	1.9	215	1,958
Michigan.....	* 322	1,671	5.6	* 205	61.7	* 12,676	24,627	2.0	* 757	* 14,091
Minnesota.....	447	1,647	3.7	156	35.3	2,286	4,052	2.1	131	2,044
Nebraska.....	58	330	5.3	24	75.8	1,885	2,55	2.5	95	631
North Dakota.....	0	0	0	0		* 1,233	2,788	2.3	35	602
Ohio.....	447	* 91		306	66.5	* 4,034	10,602	2.7	321	4,446
South Dakota.....	91	257	2.8	46	49.5	1,090	3,194	2.9	175	928
Wisconsin.....	* 627	* 726	1.2	16	2.6	* 3,382	7,433	1.9	14	3,124
Southeastern region:										
Delaware.....	182	414	2.3	118	64.6	1,290	2,819	2.2	0	3,692
Dist. of Col.....	5,108	23,257	4.6	2,320	45.4	3,534	15,221	4.3	0	3,048
Florida.....	* 3,656	13,153	3.4	879	22.8	5,228	13,526	2.6	119	3,141
Georgia.....	16,895	52,798	3.2	2,697	17.5	21,216	77,098	3.6	364	14,916
Maryland.....	2,473	5,026	2.0	754	30.5	3,395	8,791	2.7	321	3,134
North Carolina.....	414,462	35,119	2.4	2,513	17.1	14,795	41,351	2.8	344	10,994
Puerto Rico.....	* 15,735	51,526	3.3	1,753	11.5	15,772	50,666	3.2	9	7,275
South Carolina.....	16,513	28,113	1.7	361	2.3	17,626	30,772	1.7	209	4,598
Virginia.....	* 6,787	23,228	3.5	2,613	41.4	* 8,051	16,880	2.3	906	4,409
West Virginia.....	1,330	2,697	2.2	334	25.1	* 2,252	* 5,685	2.5	154	* 1,379
Southern region:										
Alabama.....	8,600	26,391	3.1	2,014	23.4	14,528	36,148	2.5	467	9,723
Arkansas.....	1,576	4,759	3.0	626	39.7	2,916	6,995	2.4	42	2,062
Kansas.....	757	3,800	5.0	387	51.1	2,402	7,413	3.1	461	* 1,701
Kentucky.....	2,223	28,404	3.1	1,982	21.5	11,876	29,216	2.5	2,490	4,105
Louisiana.....	1,677	5,395	3.1	806	48.1	4,205	11,299	2.7	146	3,057
Mississippi.....	8,497	11,903	1.4	1,093	12.9	12,221	26,862	2.4	* 289	9,526
Missouri.....	1,269	3,608	3.0	492	36.6	2,424	4,966	2.0	35	1,787
Oklahoma.....	960	2,036	2.1	256	26.9	2,781	6,773	2.4	272	2,522
Tennessee.....	* 4,711	16,115	3.8	* 1,724	36.6	11,692	35,054	2.9	1,700	9,399
Texas.....	2,855	11,083	3.9	610	21.4	6,736	25,904	3.0	43	6,791
Western region:										
Alaska.....	48	158	3.3	14	29.2	332	939	2.8	23	296
Arizona.....	1,227	3,905	3.2	467	38.1	1,569	5,637	3.6	129	1,178
California.....	* 2,237	7,562	3.1	* 1,237	50.8	* 4,226	11,446	2.7	* 831	* 4,097
Colorado.....	707	2,341	3.3	361	51.1	2,253	7,373	3.2	862	2,065
Hawaii.....	2,435	9,695	3.7	1,152	43.7	2,318	9,944	3.4	0	2,616
Idaho.....	194	611	3.1	108	95.7	* 642	2,179	3.3	217	729
Montana.....	24	121	5.0	25	104.2	1,611	3,695	2.3	133	1,413
Nevada.....	29	75	2.6	18	52.1	* 381	1,079	2.6	34	169
New Mexico.....	1,323	2,991	2.3	367	27.7	3,820	7,565	2.3	39	2,219
Oregon.....	214	953	3.1	130	60.7	1,135	3,567	2.7	72	946
Utah.....	583	1,478	2.5	167	28.6	* 1,409	* 4,536	3.2	71	* 916
Washington.....	* 925	2,499	2.7	190	20.5	2,684	7,085	2.5	73	* 3,348
Wyoming.....	10	12	1.2	0		591	1,240	2.1	20	461

* Obvious or apparent error in reporting, or report incomplete.

† Not reported.

Note.—The symbols D 1, D 3, etc., refer to time of the quarterly activities reports, MCH-51.

APPENDIX TABLE B
INFANT, PRESCHOOL, AND SCHOOL-ENTRY SERVICES, CALENDAR YEAR 1940

State	Medical service																Dental inspections				Nursing service			
	Individuals admitted	Infant		Preschool		Individuals admitted	Visits		School examinations by physicians	Dental inspections		Individuals admitted	Visits		Individuals admitted	Visits		School						
		Total	Average per admission	Total	Average per admission		Preschool	School		Total	Average per admission		Total	Average per admission		Total	Average per admission							
(N 1)	(F 3)	(N 8)	(N 30)	(F 2)	(N 14)	(F 7)	(N 2)	(N 5, 6)	(N 9)	(N 12, 13)	(F 5, 7, 6)													
Total.....	174,840	515,285	2.9	296,761	573,625	1.9	1,608,958	64,721	1,160,372	449,798	1,452,049	3.2	523,582	1,226,628	2.3	1,526,229								
Northwestern region:																								
Alaska.....																								
Connecticut.....	1,941	1,618	2.3	4,393	9,937	2.2	0	5,698	2,998	1,174	3,046	2.6	3,105	5,630	1.8	0								
Delaware.....	776	* 610	1.0	2,262	* 3,222	1.0	832	1,456	7,983	6,454	15,045	2.3	12,595	27,989	2.2	5,790								
Idaho.....	336	336	1.0	2,728	2,728	1.0	152	3,043	1,647	340	* 1,565	4.6	885	2,409	2.6	1,666								
Maine.....	515	1,534	1.7	2,995	3,014	1.2	33	111	0	2,122	7,576	3.6	3,034	30,967	3.6	46								
Massachusetts.....	1,904	6,800	4.5	6,623	2,975	4.6	0	0	38,736	228,219	5.9	* 72,639	175,502	2.4	78,532									
New Hampshire.....	17,559	91,712	5.2	18,342	59,660	3.2	0	5,213	1,283	36,222	195,461	4.3	* 33,397	133,699	3.1	138,690								
New Jersey.....	* 6,034	36,198	6.0	* 2,535	27,565	10.9	* 246,013	* 626	* 18,395	* 6,939	28,464	3.2	* 2,468	7,624	3.1	30,624								
New York.....	674	3,078	3.5	2,081	1,954	5.6	* 2,943	0	739	6,495	18,495	3.1	12,609	29,382	2.4	1,221								
Pennsylvania.....	284	342	1.2	1,441	2,050	1.4	* 5,210	1,403	188	861	3,608	1.2	1,615	4,416	2.4	3,110								
Rhode Island.....																								
Terrell.....																								
North Central region:																								
Illinois.....	428	918	2.1	1,232	1,942	1.6	16,006	* 1,457	25,566	* 2,799	7,752	2.8	* 635	1,679	2.3	8,994								
Indiana.....	* 50	226	4.5	1,458	5,105	3.6	15,151	* 1,276	28,356	* 4,722	39,400	3.9	* 6,979	77,716	2.2	67,937								
Iowa.....	483	816	1.9	1,366	605	1.7	12,416	137	6,644	2,895	7,232	2.5	2,287	3,335	1.5	20,165								
Michigan.....	* 2,450	4,199	1.7	8,690	10,035	1.1	58,280	1,404	43,568	* 24,926	51,371	2.1	* 32,922	62,224	1.9	93,612								
Minnesota.....	1,312	3,478	2.7	2,862	5,000	1.7	27,673	1,150	34,097	5,070	12,554	2.5	6,257	10,907	1.7	66,478								
Nebraska.....	30	51	1.7	0	0	0	* 5,160	2	2	904	3,114	1.4	892	* 2,115	2.4	4,907								
Nevada.....	1,074	1,074	1.0	5,922	5,922	1.0	0	0	2,368	5,973	2.5	3,426	7,574	2.2	10,394									
Ohio.....	1,553	* 1,533	2.3	5,187	10,387	2.0	95,242	1,311	37,327	16,449	33,556	2.0	15,046	35,967	2.4	75,754								
South Dakota.....	* 146	161	2.5	* 521	1,096	2.1	3,626	446	5,130	1,660	5,791	3.5	2,210	4,619	2.2	6,166								
Wisconsin.....	* 3,359	4,453	1.3	6,731	10,283	1.2	8,371	44	10,334	* 6,575	12,684	1.9	* 8,548	14,346	1.7	20,659								
Southeastern region:																								
Alabama.....	1,282	6,028	4.7	* 2,292	3,618	1.7	11,259	1,519	21,423	5,144	15,078	2.9	3,188	6,572	2.7	20,063								
Dist. of Col.....	7,956	29,936	3.8	8,725	23,878	2.7	(N)	(N)	4,662	21,316	4.6	1,671	12,464	3.4	12,208									
Florida.....	2,004	4,561	2.3	2,733	6,064	2.2	42,289	313	17,311	4,717	12,707	2.7	5,439	14,343	2.6	22,516								
Georgia.....	10,084	22,612	2.3	13,052	23,941	1.8	113,186	1,063	105,324	* 25,122	64,325	2.6	22,589	54,356	2.4	54,575								
Maryland.....	3,116	5,946	1.9	10,533	13,258	1.3	44,737	1,639	29,460	7,621	22,936	2.9	* 9,908	* 12,803	2.2	15,730								
North Carolina.....	10,115	23,618	2.4	* 22,956	31,793	1.4	64,151	* 4,462	122,099	39,187	62,273	3.2	16,100	34,161	2.1	39,440								
Puerto Rico.....	* 21,465	64,314	3.0	* 12,929	44,899	3.6	27,473	189	13,183	15,625	69,286	5.6	* 12,963	48,293	3.7	10,718								
South Carolina.....	5,397	8,774	1.6	6,328	8,770	1.4	31,091	1,235	16,753	7,294	22,784	3.1	1,742	14,682	2.1	15,936								
Texas.....	* 7,228	21,903	3.0	* 11,317	23,010	2.0	30,351	* 3,693	* 53,620	* 35,104	66,543	3.7	* 7,407	20,075	2.6	32,030								
West Virginia.....	3,171	5,400	1.7	* 13,602	16,951	1.2	23,600	2,299	2,573	* 3,532	* 7,979	2.3	* 4,562	8,946	2.0	6,139								
Southern region:																								
Alabama.....	4,181	8,512	2.0	11,396	15,007	1.3	98,295	1,329	42,068	20,504	52,857	2.6	15,507	34,693	2.3	11,852								
Arkansas.....	1,689	2,256	1.2	5,646	6,346	1.1	34,142	3,099	18,249	4,194	9,461	2.3	7,121	11,094	1.6	7,705								
Kansas.....	880	3,969	4.5	3,880	4,826	1.3	16,853	1,521	36,498	3,258	14,907	4.6	2,476	7,153	2.9	35,212								
Kentucky.....	8,956	22,717	2.5	15,518	29,062	1.7	108,462	1,014	52,731	16,648	39,341	2.4	25,352	56,665	2.2	53,623								
Louisiana.....	1,949	3,146	1.6	3,449	4,087	1.2	42,590	0	547	6,608	11,131	2.4	4,561	7,512	1.6	3,558								
Mississippi.....	3,760	4,338	1.2	9,414	10,162	1.1	42,913	3,942	68,048	17,646	37,616	2.1	39,395	52,663	1.5	14,618								
Missouri.....	* 1,770	4,966	2.8	2,041	5,556	2.7	26,236	1,304	35,350	1,532	7,119	2.1	2,766	4,996	1.8	12,199								
Oklahoma.....	1,641	2,839	1.5	6,846	7,717	1.3	27,244	6	12,181	4,768	12,615	2.6	6,690	23,901	2.4	10,625								
Tennessee.....	7,101	21,286	3.0	* 16,211	22,961	1.4	123,270	757	31,279	19,389	66,111	3.2	30,544	56,246	1.6	51,779								
Texas.....	4,393	15,139	3.4	6,022	12,751	2.1	37,071	1,827	96,746	29,552	69,469	2.8	18,722	59,224	3.5	52,487								
Western region:																								
Alaska.....	* 126	223	1.8	* 100	279	2.8	3,609	* 290	739	4,165	5.6	671	2,442	3.6	7,090									
Arizona.....	1,747	5,093	2.9	1,219	2,841	2.1	10,959	62	13,629	2,969	11,696	1.9	2,130	7,179	3.4	4,688								
California.....	9,929	27,469	2.8	15,629	39,332	2.6	36,988	4,503	19,942	10,584	27,096	2.6	9,790	23,304	2.2	66,895								
Colorado.....	5,829	1,993	2.9	1,380	4,649	3.5	2,093	102	4,592	3,220	12,178	3.6	1,591	8,786	2.4	16,008								
Hawaii.....	5,395	18,652	3.5	6,082	15,965	2.6	9,057	0	58,693	390	23,595	5.7	5,220	12,626	2.6	2,518								
Danville.....	919	1,369	2.3	2,024	2,639	1.3	6,517	260	609	4,401	5,832	4.2	1,443	3,337	2.3	7,940								
Montana.....	478	1,107	2.3	1,043	2,668	2.1	10,070	260	* 3,365	4,395	9,091	2.1	5,964	11,243	1.9	36,578								
Oregon.....	314	746	2.4	590	1,378	2.0	861	560	4,167	549	3,766	1.5	1,532	1,919	1.9	5,138								
Terrell.....	2,003	3,467	1.7	4,405	6,525	1.5	11,142	103	2,351	5,944	14,928	2.5	8,780	17,368	2.0	30,417								
New Mexico.....	1,256	2,675	2.1	3,156	6,517	2.1	32,789	803	33,660	2,419	7,277	3.0	1,830	7,602	2.0	36,994								
Utah.....	1,923	5,195	2.7	3,817	10,785	2.6	17,765	1,363	17,663	6,004	13,604	2.7	1,789	6,004	1.8	46,407								
Washington.....	1,036	5,916	3.6	* 7,712	6,370	1.9	17,095	1,536	16,327	5,621	15,078	2.6	4,376	13,644	3.1	63,496								
Wyoming.....	119	164	1.4	158	205	1.3	* 237	5	* 3,802	809	2,278	2.8	553	1,479	2.7	1,353								

*Obvious or apparent error in reporting, or report incomplete.

Not reported.

Note.—The symbols N 1, N 3, etc., refer to items of the quarterly activities reports, WCB-51.



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*** Monthly Bulletin ***



AIRPLANE MECHANIC AND APPRENTICE

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

OCTOBER



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• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Apprenticeship Moves Ahead

By CLARA M. BEYER, *Assistant Director, Division of Labor Standards, U. S. Department of Labor*

SKILLED workers have become the Nation's foremost strategic resource. Under the impact of the defense program, a crying need has developed for highly trained workers in such industries as aircraft, machine tools, and shipbuilding. The country is thus forcibly reminded that industry still depends on the skilled mechanic and that it has failed to provide sufficient training in years past. And that is true even of the industries whose final product rolls off an assembly line. The automobile industry, for example, is dependent upon its toolmakers, patternmakers, machinists, bench hands, and bench mechanics.

Apprenticeship is the best way to train these all-round, skilled mechanics. There is, to be sure, widespread and pressing need for certain types of short-term training to develop workers skilled not in any whole trade but in a single occupation, or the operation of a single machine. But the short-term training programs in no way duplicate nor should they obscure the need for apprenticeship training in a number of skilled trades which require at least 2 years—and in many cases 4 or 5 years—to learn.

Young people interested in learning a skilled trade have a much better chance of getting a sound training today than they would have had 2 years, or even 1 year, ago. Principles of sound apprenticeship are taking hold; most notably, apprenticeship programs are being launched in

the manufacturing industries. Until national defense took over the industrial scene, apprentice training programs were restricted almost entirely to the building trades.

The pressure of defense suddenly awakened both national consciousness and management alertness to the need of long-range training programs. Plants felt shortages in certain vital skills. Many plants found they could not add a needed second or third shift because of a lack of skilled mechanics or because of a shortage of supervisory personnel. Both shortages stemmed from a neglect of training in past years. On the other hand, plants which had been doing a real job of apprentice training were able to expand vigorously and with fewer growing pains.

The industries in which needs for skilled labor have been most dramatic—machine tools and machinery, aircraft, shipbuilding—have naturally been those in which apprenticeship has made the most rapid strides in the past year. To meet industry's demand for technical and promotional service in these fields, the Federal Committee on Apprenticeship, national advisory board for the promotion of sound standards of training, has put on its staff national specialists in each of these industries. These specialists supplement the general work of the Committee's rapidly expanding regional field staff.

How these apprenticeship experts work with industry—particularly with defense plants—may best be illustrated by a case story, one which shows the experience of hundreds of plants.

THE STORY OF ONE PLANT

The L. G. Banner Co. was expanding rapidly, trying to catch up with a mounting backlog of orders for machine tools. Now it was really feeling the pinch for more machinists. "Almost impossible to get them," said the personnel manager. Everywhere it was the same story. Skilled men could no longer be obtained in the open market. But training was an almost untapped resource. The latent power of the American workman was there to be developed.

The company decided that it was high time to set up an in-plant training program. One part of that program would be to "upgrade" the workers of varying degrees of skill already employed in the plant. The other part of the program would be a sound plan of apprenticeship.

After the company had called the regional office, a representative of the Apprenticeship Section of the United States Department of Labor met with management officials and with representatives of the union and reviewed the whole situation: Present and future needs of the plant for manpower; what other plants were doing to train men; how apprenticeship actually contributes to production from the start, and contributes increasingly from then on; standards for selecting apprentices; what processes to teach, in what order, and how much time should be given to each process; what related class work to give.

Management officials and the apprenticeship field man went over the trades in the plant which called for training through apprenticeship, floor space and supervisors available to do the training, and a host of other practical questions. They looked over sets of apprenticeship standards already in successful operation elsewhere—schedules of job processes and job advancement—ways and means of grading the experience of men already employed in the plant—methods of enlisting employee coopera-

tion through a joint apprenticeship committee.

The company set up a joint apprenticeship committee in the plant, composed of an equal number of management and union representatives. The joint committee met in real give-and-take sessions to work out the practical content of the training program; the ratio of apprentices to skilled workers; wages and hours of the apprentices to be hired. The company took up its recommendations and put the whole plan in writing. And the Banner apprenticeship program was well on its way, training the men desperately needed by the plant and by the country.

FEDERAL COMMITTEE ON APPRENTICESHIP

This story shows one aspect of the work of the Federal Committee on Apprenticeship, and of the Apprenticeship Section, which is a part of the Division of Labor Standards of the United States Department of Labor. The Committee itself is composed of outstanding employer and labor-union representatives, with a representative each from the United States Office of Education, the National Youth Administration, and the Department of Labor. Its function is to crystallize broad policies of apprentice training and promote their use in industry.

National standards for apprenticeship are useful only as they help management and labor themselves in the promotion and setting up of the right sort of training plans. Further help in promotion and in setting approved standards is provided by the State apprenticeship councils, now functioning in 24 States. These councils bring together employer and employee spokesmen, along with representatives of State vocational education and State labor departments.

During their 1941 legislative sessions, 4 States passed basic apprenticeship laws, making a total of 15 States that have such laws.

A State apprenticeship act does not automatically produce an actively functioning State program. The gap may be due to lack of appropriations and special personnel. There are still only eight States that have a full-time director of apprenticeship and two States that

employ a part-time director. However, when one recalls that the Federal Apprenticeship Act was passed as recently as 1937, one sees that the States are making sure progress.

COOPERATION, NOT COERCION

Apprenticeship uses the democratic approach of bringing employer and labor groups together to work out their problems with the technical aid of Government experts on a National basis, on a State basis, in the local community, and in the plant itself.

Management has the initiative, but labor's stake is equally vital. Management is looking for trained workers for the years ahead; it must launch the plans and hire the apprentice workers. Labor wants to pass on its skilled craftsmanship to the next generation of workers; at the same time it must safeguard the standards and the welfare of the skilled men already trained.

Joint committees, at the local, State, and National levels, carry through this common purpose. In developing their standards and in setting up specific plant programs for apprenticeship, management and labor call upon the experience and pooled information of apprenticeship experts, vocational-education specialists, and employment-service representatives.

The procedure is voluntary all the way through. This may seem slow and cumbersome. But it is a method which will work—even if it has taken the Nation's grave emergency to bring the need home.

Results can be seen, most notably, in the growth in the number of approved apprenticeship plans in individual manufacturing establishments. There were a scant 22 such plans in June 1940; by August 1941 there were 356 plans in individual manufacturing establishments. The total number of approved plans of all types jumped during the year from 521 to 975. In many of these approved plans numerous manufacturing establishments are included under a single plan; for instance, in Houston approximately 25 plants operate under a single set of approved standards.

During the past year apprenticeship plans, under standards approved by Federal and State

apprenticeship bodies, have been adopted by such outstanding firms as these: Vultee Aircraft, Bendix Radio, Worthington Pump & Machinery, Yale & Towne, American Bridge, Consolidated Shipbuilding, New York Shipbuilding, Todd-Bath Iron Shipbuilding, American Cyanamide, Colorado Fuel & Iron, Remington Arms.

THE PROSPECTIVE APPRENTICE

Now for a practical question: What advice can one give the boy who may want to become an apprentice?

To begin with, a boy should have completed at least the first 2 years of high school, and he is better off, as a rule, if he has completed all 4 years. He must be at least 16 years of age, preferably 18.

He ought to know that apprenticeship is a long and serious undertaking. The shortest apprenticeable trade requires 2,000 hours—or 2 years—to learn; many trades require 4 or 5 years. Most of his training the apprentice of course gets in the plant; that is where the work is done, and that is where it must be learned. A few hours each week are spent in related school work; this has its practical side in the needs of his chosen trade, but it should go further, with the design of making the apprentice a better-rounded man and citizen.

All this adds up to a fairly rigorous, serious-minded period of training. The young apprentice may see other boys he knows going into jobs on the assembly line and making higher wages than he is earning—with no obligation to study at night! But he is learning a trade he will use all his life—and if the training is sound, it will be for no blind-alley work.

As for wages, the apprentice will soon pass those who have gone into work requiring less skill. He begins at about one-fourth the journeyman's wage; as he advances in skill and responsibility, his pay goes up accordingly, until toward the close of his apprenticeship, he should be making about three-fourths of the journeyman's pay. Over the whole period, he should average about half the skilled man's wages.

To become an apprentice, a boy must first get a job as an apprentice. The major clearing

house for information on jobs is the State employment service. The public employment office should have information on apprenticeship programs in local plants, and it may refer the boy to an opening. At many local public employment offices, moreover, the boy may receive vocational-aptitude tests which will help him decide whether he is really fitted to become a machinist or carpenter or electrician or airline mechanic.

Teachers of vocational courses in the high school may be able to help the boy in making up his mind about his life work. Labor unions will also have information on apprenticeship plans in their own trades or industries. If the boy's father is in the skilled trades or in a plant which has an apprenticeship plan he can help considerably.

If the boy is in a town where there is no public employment office, he should write to his State labor department for information.

Apprenticeship involves an agreement between apprentice and employer. The best agreement, in any dealing, is a written agreement. The best apprenticeship agreement is one which is put into a definite indenture signed by the apprentice and his parents on the one hand, and the employer on the other.

Employers have found that if they have written agreements, exactly defining the responsibility of each party, the apprentice is much likelier to finish his period of apprenticeship.

The agreement should describe the trade to be learned and set forth clearly such things as the schedule of processes and the order in which the apprentice is to be taught them, the hours to be worked and the wages to be paid, and the steps by which the apprentice's pay is to go up as he gains skill and experience. It should provide for related school work. It should include a probationary period, during which either party may call off the agreement.

These are some of the things the boy who wants to enter a skilled trade, and his family, should know. After that, if they think the idea is worth while, it is up to him to land a job as an apprentice.

* * * * *

More and more young men will want to know these things, as the skilled trades continue to call for trained hands and minds. With many years of neglect of training to make up for, the country still does not have half enough apprentices to meet all industrial demands.

Emergencies throw a new light on long-standing needs. Defense has not created the problem of training, but it has deepened and dramatized it. Today, while the Nation mans the machines for production, a production so immediate and so engulfing that few of us realize its magnitude, we need both to make up for lost time in training workers, and to build hard and strong for the future.

Child Labor and the Defense Emergency

BY ELLA ARVILLA MERRITT

Industrial Division, U. S. Children's Bureau

"Factory whistles blowing, men at work again," might be this country's 1941 slogan. Hundreds of thousands of new jobs have opened up under the national-defense program—hundreds of thousands of unemployed persons have been put to work.¹ Federally sponsored technical courses in schools and colleges are training thousands of youths for jobs in defense industries. Young people as well as adults are sharing in this increase in employment. It is important to consider what has been, and what will be, the total effect of this resurgence of employment opportunity upon the most valuable resource of the Nation—its children and youth.

It is fully recognized, as the President said in his Labor Day statement, that "there must be full and uninterrupted production of the weapons and materials needed for our protection and needed also by the nations engaged in opposing those who would do away with the liberty and happiness of free peoples all over the world." But it is recognized too, as the President has also emphasized, that "Later we shall need men and women of broad understanding and special aptitudes to serve as leaders of the generation which must manage the post-war world."² In other words, "total

defense" means not only stepping up production of material supplies to provide for today's needs; it means also safeguarding the Nation's future strength by constant and increasing protection of the health, education, and social welfare of the young people in whose hands the future of our Nation lies.

In working for this protection of the health, education, and social effectiveness of youth, the problems of child labor demand two differing approaches, the first in regard to the employment of children under 16, and the second in regard to the employment of boys and girls of 16 and 17 years. For a number of years public opinion in this country has been developing toward the conviction that the years of a child's life up to 16 should be devoted to physical, mental, and social growth rather than to full-time wage earning. On the other hand, the entrance of 16- and 17-year-old boys and girls into industry has been generally recognized as permissible and often advantageous, provided they are given the benefit of vocational counsel and suitable placement and are guarded against unfavorable working conditions. Yet when present sources of information are examined, an upward trend in employment is evident for both workers under 16 years of age and those 16 and 17 years of age, though much more accentuated for the latter group.

"Straws show which way the wind blows," and evidences from various parts of the country indicate this upward swing in the number of young persons at work, particularly in areas where defense production has taken older workers from their former jobs. The children under 16 are going chiefly into nonfactory jobs, for instance, in delivery work, for news distributing agencies, and in stores—employment on

¹Total civil nonagricultural employment in August amounted to 39,542,000, which was 1,166,000 above the August 1929 level and an increase of 3,640,000 workers since August 1940. From July to August employment increased by 261,000, July being the fifth consecutive month in which employment exceeded all previous levels. (Press Release (12763), Office of the Secretary, Department of Labor, September 30, 1941.) Job placements by public employment offices during May topped the half-million mark for the first time since January 1936, a month in which, moreover, the greater part of the placements were on public works and work-relief projects. The 500,100 jobs filled in May 1941 were 13 percent above April and 43 percent above May 1940. (*Monthly Labor Review*, August 1941, p. 420.)

²Letter to American College Publicity Association, July 22, 1941.

the whole less subject to regulation than factory work. However, where not prevented by a 16-year minimum-age standard, some children are going into local manufacturing industries. For instance, reports came to the Children's Bureau this summer that some canning establishments were increasing their use of younger workers, even under 16 years, whereas formerly they had employed chiefly older girls.

There is evidence also that in some localities where considerable pressure on the labor supply exists, there may be a drift into employment that is illegal for these children. Reports are already coming of difficulty in enforcing school-attendance and child-labor requirements because children are picking up jobs which they could not fill legally but which are open and tempt them to leave school. This is found particularly in areas where there has been great expansion in employment so that jobs are easy to find. There has also been an unusual demand for child labor in agriculture, and in some localities there has been a tendency to retard the opening of schools or to excuse children from attendance for this work.

Many of the new jobs for 16- and 17-year-old minors are in manufacturing industries, if such work is available in the locality, though the actual increase appears to be greater in retail and wholesale trade and various service occupations. An example of the situation in manufacturing is afforded by figures for Ohio, where, in the month of July 1941, certificates for manufacturing industries were issued for more than 500 minors 16 and 17 years of age. These minors were going into a wide variety of jobs in machine shops, furniture factories, shoe factories, manufacturing of machine tools, canneries, garment factories, airplane factories, and cash-register manufacturing. Some were doing clerical or assembly work, or were in such jobs as inspecting and packing, but many were machinists' helpers or machine operators, or were engaged in other direct productive work.

Three measuring rods are available to obtain an over-all picture of the trend of employment of young persons under 18 years of age throughout the country, whether or not in areas where defense industries are concentrated—(1)

the 1940 decennial census returns; (2) records of the numbers of employment certificates issued, these certificates being required in most States for children going to work; and (3) figures for placements of young persons³ by public employment offices.

As pointed out in the article entitled, "The Census Counts the Child Workers of the Country," in the September 1941 issue of *THE CHILD*, a considerable reduction between 1930 and 1940 in the employment of children, particularly of those under 16, is indicated by the United States census reports. These reductions were due to various social forces operating in the decade, reflected to some extent in State and Federal legislation, as well as to lack of employment opportunity. But the picture has radically altered since March 1940 when the census was taken, and employment of young persons is increasing with increased employment of older workers.

Reports of employment certificates, which must be obtained under most State laws for minors going to work, serve to picture roughly the trends in employment of young persons from year to year. Since 1920 these reports have been collected by the Children's Bureau from an increasing number of localities through cooperation with State and local officials throughout the United States, and at the close of the calendar year 1940 they were being received from 42 States, the District of Columbia, and Hawaii. As is indicated by these reports, the number of minors between 14 and 18 years of age leaving school for work, taking the group as a whole⁴ began to increase in 1940, following a decline in 1939 over the 2 years previous, and has continued to rise more steeply in 1941.

As to 14- and 15-year-old children, reports of certificates permitting children to leave school

³ These figures are collected by the Bureau of Employment Security, Social Security Board, Federal Security Agency, Washington, D. C.

⁴ In the comparison of certificates issued for children 14 and 15 years of age leaving school for work in 1939 with the corresponding number in 1940, only States are included where the legal standards were similar in the 2 years, that is, where the minimum age for employment under State law was not raised to 16 during the period; if figures for New Jersey, where the minimum age for employment was raised to 16 in 1940 are included, the figures for 1940 show a slight decrease from those for 1939.

for work, issued in the first 6 months of 1940 and the first 6 months of 1941, indicate that where the State law permits such employment for children under 16, their employment was on the increase in the 1941 period. In 29 States⁵ and the District of Columbia, where the minimum age for employment during school hours was the same in both years, 2,355 first regular certificates were issued for 14- and 15-year-old boys and girls in the first 6 months of 1941 as compared with 1,236 in the corresponding period of 1940, an increase of nearly 100 percent. On the other hand, in the one State (New Jersey) where the law was amended to raise the basic minimum age for employment from 14 to 16, only 2 children of these ages left school for work in the first 6 months of 1941, whereas 1,265 had done so in the corresponding period of 1940 before the new law went into effect.

Boys and girls of 16 and 17 during this period were going to work in much larger numbers. Early in the spring of 1941 evidence of this increase was noted in reports received by the Bureau from local certificate-issuing officials co-operating in the enforcement of the child-labor provisions of the Fair Labor Standards Act.⁶ So rapid was the increase in the number of certificates requested that these officials were finding it impossible to meet the demand without additional staff. Incomplete reports from 13 States⁷ and the District of Columbia, where certificates for minors of 16 and 17 years are required under State law, show in round numbers 79,000 certificates issued in the first 6 months of 1941 as compared with 30,000 in the first 6

months of 1940, an increase of more than 160 percent. In 21 States where the State law does not require such certificates for the employment of 16- and 17-year-old minors but where they are issued on request,⁸ incomplete returns show approximately 15,000 certificates issued for such minors in 1940 as compared with 8,000 in 1939; in the first 6 months of 1941 the total rose to approximately 20,000. This figure is almost as large as the number issued in the entire 2 years 1939 and 1940 combined and represents an increase of 282 percent over the corresponding 6 months of 1940.

Reports for June and July 1941 show marked increases over the same months of 1940. In June and July 1941 in the areas reporting, 9,348 children⁹ 14 and 15 years of age went to work at regular or vacation employment, chiefly the latter, compared to 3,784 in the corresponding months of 1940, an increase of 147 percent. For the 16- and 17-year-old group the increases varied from 250 percent in States where certificates are required by law to 375 percent in States where they are not required but are issued on request. These figures are:

Certificates issued for 16- and 17-year-old minors

	June- July 1940	June- July 1941	Percent of in- crease
States and cities where certificates are required.....	8,873	31,050	250
States and cities where certificates are not required....	3,313	15,725	375

Another indication of an upward trend in employment of minors under the impact of the defense program is found in the number of placements of young persons made by public employment offices throughout the country and reported to the Bureau of Employment Security of the Social Security Board. These figures do not, however, reflect the actual extent of employment, as only a small proportion of

⁵ These States are Alabama, Arkansas, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Kentucky, Maryland, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, and Tennessee, with a 14-year minimum-age standard; Maine and Michigan, with a 15-year minimum-age standard; Connecticut, Massachusetts, North Carolina, Ohio, Pennsylvania, Rhode Island, and West Virginia, with a 16-year minimum-age standard but permitting exemptions under certain conditions; and Montana, with a 16-year minimum age for work in factories. For some of these States reports are not State-wide but cover only certain cities.

⁶ In most States, State certificates issued under the State law by these officials are accepted as proof of age under the Fair Labor Standards Act.

⁷ Alabama, Connecticut, Ohio, Georgia, Indiana, Massachusetts, Michigan, New York, North Carolina, Oregon, Oklahoma, Pennsylvania, and Tennessee. For some of these States reports are not State-wide but cover only certain cities; for certain others data for the entire 6 months' period are not available.

⁸ Arkansas, Delaware, Florida, Illinois, Iowa, Louisiana, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Vermont, Virginia, and West Virginia. For some of these States reports are not State-wide but cover only certain cities; for certain others data for the entire 6 months' period are not available.

⁹ Excluding 670 children for whom certificates for work in agriculture were issued in June and July 1941 in New Jersey, a State where certificates were not required for work in agriculture in these months of 1940.

persons who get jobs get them through such placement offices. Jobs found for 16- and 17-year-old minors¹⁰ numbered 26 percent more in 1940 than in 1939, and in 1941 the number placed rose steadily month by month from January through July, with the sharpest upturn in the last 2 months. In these 7 months together placements of 16- and 17-year-old minors were 92 percent greater than during the corresponding 7 months of 1940 (table 1).

This upswing in employment, encouraging as it is for the most part as regards 16- and 17-year-old minors, brings to the fore grave problems with respect to children under 16. The increase in the number of 14- and 15-year-old workers is not yet large, but, without sufficient legal safeguards reenforced by good administration, the situation may rapidly become serious and result in a break-down of the standards which have been developed through the years.

TABLE 1.—Number of placements by public employment offices in the United States of minors 16 and 17 years of age, by sex, January through July 1940 and 1941, and percentage increase

Month	Number of placements of minors 16 and 17 years of age						Percent increase 1940-41		
	1940			1941			Total	Boys	Girls
	Total	Boys	Girls	Total	Boys	Girls			
Total, January through July.....	47, 017	22, 390	24, 627	90, 190	51, 288	38, 902	92	129	58
January.....	3, 145	1, 132	2, 013	4, 790	2, 172	2, 618	52	92	30
February.....	3, 121	1, 232	1, 889	5, 376	2, 641	2, 735	72	114	45
March.....	3, 836	1, 626	2, 210	7, 147	3, 892	3, 255	86	139	47
April.....	5, 195	2, 487	2, 708	10, 241	5, 812	4, 429	97	134	64
May.....	7, 911	4, 027	3, 884	14, 466	8, 579	5, 887	83	113	52
June.....	12, 763	6, 370	6, 393	23, 373	12, 994	10, 379	83	104	62
July.....	11, 046	5, 516	5, 530	24, 797	15, 198	9, 599	124	176	74

Compiled by the Children's Bureau from data made available by the Bureau of Employment Security, Social Security Board.

This increase in employment of young workers has extended to all sections of the country. Placements of 16- and 17-year-old boys and girls from January through July 1941 were higher than during the corresponding 7 months of 1940 in all but two States. In more than half of the States the increase exceeded 100 percent, and in eight States and the District of Columbia the number of placements at least tripled. The largest increases occurred in Indiana, Maryland, Oregon, Rhode Island, and South Carolina.

¹⁰ In the case of children under 16, placement statistics are so much influenced by legal minimum-age standards and by administrative policy regarding referrals of children of this age to employers, that they are thought not to be an accurate reflection of employment trends for this age group.

Moreover, in view of the large increase in employment of boys and girls of 16 and 17 at this early stage of the defense program, care must be exercised to see that the new employment opportunity will be beneficial to all youth engaged in it. Pressure toward break-downs of child-labor and school-attendance standards is already evident. Such pressure appears to be an inevitable accompaniment of the strain that accompanies any intense and Nation-wide productive effort, such as this country is now making and must continue to make. But the impact of this strain on young people must be made as light as possible. They will have a major responsibility for the character of American life for the next half century, and potential dangers to their welfare must be foreseen and averted by wise planning.

Government Labor Officials Meet

The twenty-seventh convention of the International Association of Governmental Labor Officials was held in St. Louis, Mo., September 3-6, 1941.

The report on child labor submitted to the International Association of Governmental Labor Officials by its child-labor committee summarized the effect of the defense situation on the employment of youth, and legislation passed during the year, in the United States and in Canada. In conclusion the report emphasizes that the safeguarding of youth is one of the vital aspects of national defense:

No young person should be deprived of educational opportunity or of the protective measures that make for health, safety, and morals, whether he is still in school, about to enter the labor market, or on a defense or nondefense job.

The resolutions adopted by the conference included the following statement in regard to the employment of youth:

In this critical period of increased production and expanding employment opportunity, the International Association of Governmental Labor Officials emphasizes the vital importance of maintaining protective measures which insure the education, training, and the safety, health, and general welfare of young workers, and recommends that every effort be made to:

1. Maintain existing protective legislation;
2. Extend such protection to occupations or fields of

employment now not adequately covered, such as commercialized agriculture and street trades; and

3. Develop more effective regulation of employment of minors in occupations particularly hazardous to health and safety.

The Association, recognizing the importance of safeguarding not only the condition of employment but also the opportunity of employment for youth in desirable and legal occupations, further urges the extension of guidance and specialized placement services for young persons through public employment services.

A resolution on labor standards in relation to national defense urges the maintenance of wage-and-hour standards and of collective bargaining. One on industrial home work expresses approval of the action of the Administrator of the Wage and Hour Division in prohibiting industrial home work in the jewelry industry and urges that he consider the prohibition of home work in any industry in which it is important. A resolution on apprenticeship training requests the proper government agency to consider including provision for the training of apprentices in contracts for defense goods in situations which lend themselves to such training.

Other resolutions deal with the prevention of accidents and occupational diseases and with machinery safety requirements. A resolution in support of the International Labor Organization was also adopted.

• THE WORLD'S CHILDREN •

Child Welfare in the Defense of Some British Dominions

BY ANNA KALET SMITH

Office of the Chief, U. S. Children's Bureau

The British Dominions, in their mobilization for defense, singled out improved health of the civilian population, particularly that of children, as one of their chief aims. Despite the divergence in the geographic, social, and economic conditions of the Dominions, a certain similarity is found in their aims and methods. Even before the outbreak of the war in 1939, with the international situation becoming increasingly tense, Australia, New Zealand, and the Union of South Africa introduced comprehensive physical-fitness and nutrition programs as a means of strengthening the people against future contingencies. The programs have been continued and even expanded in the face of wartime difficulties, together with peacetime child-health services.

Other actions aimed at improving the well-being of the people and consequently the power of defense have been taken: In Australia the child-endowment system has provided since July 1941 regular monthly allowances for each child under 16 in a family except the first; in the Union of South Africa, the Factories Act of 1941, effective September 1, raises the minimum age for employment to 15 years and aims in other ways to safeguard more effectively than heretofore the workers' health at a time when, under the pressure of war, labor standards are relaxed in many countries; in New Zealand, free health services for all residents were introduced in 1939 and extended in 1941 under the Social Security Act of 1938. This act, which unites the people in one body for the

purpose of relieving economic distress and protecting health, is a defense measure of outstanding significance.

CAMPAIGN FOR PHYSICAL WELFARE

1. *Australia.*—With increasing public recognition of the need for physical fitness and efficiency in Australia the National Health and Medical Research Council, an official body, recommended in 1938 the appointment of a Commonwealth Council for National Fitness. The Council, appointed by the Commonwealth Government, began to function early in 1939. Similar councils were later organized in the individual States.¹

The Commonwealth Council aims to develop appreciation of the benefits of physical well-being and to provide for every individual an opportunity for obtaining a knowledge of the principles of physical education and health. The Council coordinates and supplements the work of all agencies aiming at the improvement of the physical condition of the people through economic, nutrition, and other measures.

All the work done by the Commonwealth Council since 1939 for the improvement of the national physique was given permanence by a law of July 4, 1941, which assured the continuation of the Council and established a national-fitness fund from grants by Parliament and from other sources.

¹ Statement by the New York office of the Australian Associated Press, October 27, 1940.

In addition the Commonwealth and State health authorities of Australia began in 1940 a Nation-wide health drive to inform the public of the preventive and curative health services available. Education of the public through the press, radio, and motion-picture film is a part of the drive.

2. *New Zealand.*—In New Zealand, where physical welfare was the subject of a special conference in 1937, a National Council of Physical Welfare and Recreation was established under a law ² of the same year amended in 1938. The Council, under the chairmanship of the Minister of Internal Affairs, is directed by the law to advise the Government on matters relating to the maintenance and improvement of the physical well-being of the people by means of physical training, exercise, sports, recreation, and related social activities; to make investigations on these subjects; to recommend action; and to direct public interest to the national value of physical welfare and recreation.

3. *Union of South Africa.*—Public demand for a higher national standard of health and for a better knowledge of the rules of health became manifest in the Union of South Africa shortly before the war began in 1939. In partial response to this demand the National Advisory Council for Physical Education was organized in 1938, and in January 1940 a committee of experts was appointed by the Council to organize a system of physical education. The Council administers the funds granted by the Government for physical education, which amounted in the two fiscal years 1938-39 and 1939-40 to £50,000 ³ (\$199,000 according to the rate of exchange in 1940).

NUTRITION PROGRAMS

1. *Australia.*—The Australian delegates to the Assembly of the League of Nations and the International Labor Conference in 1935 ⁴ were instrumental in inspiring a concerted international inquiry into world-wide problems of nutrition, with a view to preventing malnutri-

tion by greater consumption of protective foods. The Government of the Commonwealth of Australia appointed in 1936 an Advisory Council of Nutrition composed of experts representing health and agricultural interests with the Commonwealth Director General of Health as chairman.

This Council proceeded to make a survey of family diets in Sydney, Melbourne, Brisbane, Adelaide, and Perth, and a survey of the nutritional state of children in inland areas. The local organization of the inquiry was furthered by the appointment of State committees. Five progress reports were followed by the final report in September 1938, which revealed that malnutrition was most pronounced among children in the far-inland areas and in the poorer sections of the cities. The Council, before disbanding, recommended the appointment of a central committee to work for the improvement of child health, to promote teaching of better food habits to the people, and to take other corrective measures. The Nutrition Committee was appointed by the National Health and Medical Research Council, a Government agency, and continued the work of the Council on Nutrition.

It has been reported that at least some of State nutrition committees conducted educational campaigns by means of the radio, the press, and lectures and that the effects of such campaigns had been noticed in the changing food habits of the people and in the increased demand for milk, fruit, salad vegetables, and wheat-germ bread.⁵

The Nutrition Committee has continued its studies of the Australian diet with a view to insuring that the proper kinds and quantities of foods are obtainable at low prices and encouraging their regular use. Nutrition of pre-school children has been studied at special demonstration centers established in several cities by the Commonwealth Government and directed by the Institute of Anatomy at Canberra, with the cooperation of the Australian Association for Preschool Child Development. The Government has stated through the press

² New Zealand Statutes, 1937, p. 57.

³ Union of South Africa, Report of the Union Department of Education for 1939 (includes part of 1940).

⁴ *Health*, Journal of the Commonwealth Department of Health, April 1939 and October-December 1940.

⁵ *Journal of the American Medical Association*, April 22, 1939.

that it is not allowing wartime difficulties to arrest the progress of this work.⁶

2. *New Zealand.*—Nutrition is being studied by a special nutrition committee of the New Zealand Medical Research Council, associated with the Dominion's Department of Health. A technician is employed by the committee on a full-time basis; in addition a medical officer was appointed in 1940 to the staff of the Department of Health for research in connection with infant nutrition. In the fiscal year 1940-41 the committee, in cooperation with other organizations, made a study of the vitamin B₁ content of bread and prepared a plan for the study of the nutritional status of the population in regard to vitamin B₁ and vitamin C. The Medical Research Council, although handicapped in its work by the war, has been consistently encouraging the continuation of investigations by its committee. In the same year a full-time nutritionist was appointed to the staff of the Department of Health; the nutritionist participated in the formulation of plans for the medical supervision of preschool children and improvement of their diet. Under the auspices of the Department of Health radio talks and lectures were given; articles were published in the daily and periodical press; a nutrition exhibit was arranged at the Medical School of Otago University for popular education and teaching of medical students.

The distribution of free milk to school children, begun before the war, has been progressing gradually, so that in 1941 milk was available to 81 percent of the school population. The children who have received milk in school have gained in weight; the teachers also attribute to the use of milk improved school attendance, decreased fatigue, and greater alertness. The distribution of free apples to children in all types of schools during a period of 10 weeks was also introduced in 1941; the cost is met by the Department of Health and the Department of Primary Products Marketing.

The number of health camps for children is increasing; in the school year 1940 arrangements were made for building or extending camps at

nine places, and in 1941 negotiations were in progress for acquiring sites in other places.

In the fiscal year ended March 31, 1941, the Department of Health of New Zealand decided to open clinics staffed by school physicians and public-health nurses for the examination of children between the ages of 1 and 5 years, the group heretofore not reached by preventive health work. Only one such clinic operated early in 1941 but the opening of others was planned.

Dental services for school children, like medical examinations, not only continued after the advent of the war but were extended. There were 358 treatment centers early in 1941 against 321 in 1939, and the number of children who received regular dental treatment in the year ended March 31, 1941, increased by 7,000.⁷ As in previous years treatment was given to children in the first four grades, but plans were also made to include the fifth grade. The Dominion Training School for Dental Nurses and Wellington Dental Clinic, a treatment center for children of the Wellington metropolitan area, were opened in the same year.

3. *Union of South Africa.*—The Union of South Africa, like Australia and New Zealand, took note of the recommendations made by the League of Nations for improving the people's nutrition. The first step in that direction was the granting by the South African Parliament in 1938 of £6,000 (about \$29,000 according to the rate of exchange in 1938) for a nutrition survey of children of European origin in the Union. The report of the survey, prepared by the Department of Health in February 1940, showed that 40 percent of the boys and 33 percent of the girls were malnourished. As a result several more intensive studies of the causative and correlative factors of malnutrition have been undertaken.

The public interest aroused by this survey resulted in the setting up in June 1940 of a National Nutrition Council to investigate and report to the Minister of Public Health on all matters relating to the improvement of the

⁶ Release by the Australian Associated Press, October 27, 1940.

⁷ New Zealand Department of Health, *Annual Report for the Year Ended March 31, 1940*, p. 5; and for the *Year Ended March 31, 1941*, pp. 5-21.

people's diet and the prevention of malnutrition among them.

Although the Council has undertaken the major portion of the work in connection with the prevention of malnutrition, the Department of Health is still concerned with nutrition and dietetics and is continuing its work in this field; for example, it supervises the dietary departments of institutions under its control, it gives advice on matters relating to nutrition and dietetics to all Government and private agencies, and conducts a campaign of health education through the press, Government publications, correspondence, lectures, and demonstrations.

Investigations into the dietetic, clinical, sociological, and economic aspects of malnutrition on behalf of the Department of Health were being continued in 1940 by two universities and the South African Institute for Medical Research.⁸

CARE OF CHILDREN BROUGHT FROM THE UNITED KINGDOM

Soon after the outbreak of the war in September 1939 the British Dominions offered to receive children from the United Kingdom. A committee was set up in London by the Dominions' Office to formulate plans. The Children's Overseas Reception Board was appointed and was responsible for the selection, medical inspection, and transportation of children to overseas countries. Australia, New Zealand, and the Union of South Africa, like other overseas countries, made preparations to receive the children, and their Governments issued regulations for their care.

1. *Australia*.—In Australia regulations for the care of children brought from the United Kingdom were issued by the Governor General on September 17, 1940.⁹

The Minister of State for the Interior is the guardian of every such child. After the child is received in a State the guardianship becomes vested in the person who is in charge of the child-welfare department of that State or of the corresponding Government agency.

⁸ Union of South Africa, Annual Report of the Department of Public Health for the Year Ended June 30, 1940, pp. 7-8, and 81.

⁹ Australia, Statutory Rules, 1940, No. 202.

That person makes the necessary arrangements for the welfare and care of the child, whom he may place in a private home but not in an institution.

Any person desiring to take into his home a child from overseas must obtain permission from the Government agency. Each application is investigated before it is approved.

In placing a child from overseas, the State authority must observe the wishes of the child's parents or guardians in the United Kingdom and place the child as closely as possible in accordance with their wishes. The foster parent caring for the child is required to conform with the child-welfare laws of the State. The State must keep a register of all foster parents. A proposed change of the foster parent's address must be reported a week in advance.

Social workers, in some cases salaried employees of public or private welfare agencies, in other cases unpaid volunteers, were appointed to visit the foster homes and supervise the conditions under which the children are brought up.

2. *New Zealand*.—Committees were organized in 1940 in several cities of New Zealand for the purpose of receiving and examining offers of accommodation for children from the United Kingdom. Accommodation was approved for 10,000 children, but only 200 children were brought over.

Regulations issued in September 1940¹⁰ place these children under the supervision and legal guardianship of the superintendent of the Child Welfare Branch of the Education Department and extend to them the application of the child-welfare law of 1925 in regard to physical care, education, and employment.

Child-welfare officers or other agents are sent by the superintendent to visit the home and to ascertain the kind of care given to the child; the foster parent must comply with the requirements of these officers, including those concerned with the medical and dental care of the child.

The Health Department is cooperating in all matters affecting the health of the children. The Child Welfare Branch of the Education Department has been reporting regularly to the Children's Overseas Reception Board in England on the children's progress. In June 1941, about 9 months after the children's arrival, a newspaper report stated that the children were

¹⁰ New Zealand, Statutory Regulations, 1940, p. 757.

becoming accustomed to their new surroundings and were making good progress in every way.

3. *Union of South Africa*.—Regulations for the care of children brought to the Union of South Africa for the duration of the war by arrangement between the Government of the Union of South Africa and that of the United Kingdom were issued by the Governor General in 1940.¹³

The Minister of Social Welfare was entrusted with the guardianship of these children while they remain in the Union.

The Minister is assisted by an advisory council which was instituted at a conference especially called by the Department of Social Welfare in Pretoria in June 1940. Local committees have been formed under the chairmanship of magistrates throughout the Union and are reported to be giving valuable aid.

About 350 children were received from the United Kingdom in 1940. It was the policy of the Overseas Children Reception Administration to place children in private families whenever possible, but not to exclude other appropriate methods of accommodating them.

* * * * *

The sending of children overseas was discontinued by the British Government in the autumn of 1940 because of the dangers of ocean transportation.

RECENT LAWS OF CONSEQUENCE TO CHILD HEALTH

1. *Australia*.—The law on "child endowment," which was passed by the Parliament of Australia in the spring of 1941 and which came into operation on July 1, 1941, provides for an allowance of 5 shillings weekly to be paid for each child under 16 in a family except the first, irrespective of the parents' income. Adopted children and those of illegitimate birth are included.

Of the 1,830,000 Australian children under 16 years of age, 1,000,000 are estimated to come under this law. The approximate cost of £13,000,000 (\$41,964,000, according to the official rate of exchange, in July 1941) will be financed by a tax on pay rolls and by the abolition of income-tax deductions for each child

after the first, supplemented by funds from the general revenue.¹²

The allowance is paid directly to the mother or woman in charge of the child, but the agency administering the law has discretion in special cases to pay it to the father, or guardian, or any other selected person. Payments for the first month totaled £900,000.¹³

Three weeks after the law became operative the Government decided to extend its benefits without delay to children evacuated from the United Kingdom, whereas other children would be eligible only after they had lived in the Commonwealth for a year. For the purpose of the law a child from England will be considered as the foster parents' own child; the allowances for the evacuated children will be collected by the heads of the Australian families with which they are living, who will have to fulfill the requirements of the law.¹⁴

Shortly before the enactment of the law, the Minister for Labor and Social Services stated his belief that the war had emphasized the need for this aid, which would assure a satisfaction of at least the basic family needs; he also said that the Government had given much consideration to the payment of the allowance also for the first child, but in view of the Commonwealth Court's recent finding that the existing basic wage was sufficient for a man, wife, and child, the decision was made to begin payment with the second child. He added that studies of malnutrition and ill-health among children in Australia and elsewhere showed that these appeared serious only in large families and that first children were definitely in a better position.¹⁵

The allowance is considered unlikely to affect the birth rate appreciably, but it is expected to be followed by an improvement in the health of the children and a reduction in child mortality.

The present law apparently has no effect on the existing maternity-allowance law enacted in

¹² Australian News Letter, issued by the Empire Press Union, April 1941, and Bureau correspondence.

¹³ Morning Herald, Sydney, Australia, July 30, 1941.

¹⁴ *Id.*, July 22, 1941.

¹⁵ Australian News Letter, issued by the Empire Press Union, April 1941.

¹³ Child Welfare, Official Organ of the South African National Council for Child Welfare, December 1940, p. 4.

1912 under which a mother receives from the Commonwealth Treasury £5 on the birth of a child. It did bring about, however, the repeal of the family-allowance law of 1927 in New South Wales providing for regular payments for each dependent child under 14, except the first, in families with an income below a specified amount.

2. *New Zealand*.—In New Zealand the Social Security Act of 1938 with its subsequent ramifications, aiding the people in cases of illness, disability, unemployment, and other emergencies, constitutes a foremost contribution to that country's defense program.

This law, replacing the previous systems of noncontributory old-age pensions, widows' pensions, family allowances, and other benefits, requires every resident of New Zealand 16 years of age and over, to contribute to the social-security fund a registration fee and a specified fraction of his wages, salary, or other income. The incomes of companies are also subject to this charge. In return the insured persons are entitled to old-age benefits, widows', orphans', and invalids' benefits, and benefits in cases of unemployment, sickness, and other specified emergencies. Most of these benefits were introduced in 1939 and are in effect now despite wartime difficulties. The law also provides health benefits comprising maternity care, medical care for other cases, hospital treatment, pharmaceutical benefits, and certain supplementary benefits, for example, services by specialist, dental care, and home-nursing service. The various categories of health benefits are being introduced gradually; not all are available so far. It is a special feature of these benefits that they are available without extra charge, except the contributions regularly required under the Social Security Act, to all persons ordinarily resident in New Zealand, irrespective of economic status, race, or nationality.

Maternity care, introduced in 1939, consists of prenatal, confinement, and postnatal care, and the services of physicians and nurses. Confinement care may be given in a hospital or at the patient's home by a physician and nurse or by a midwife when a physician is not available. The physicians, nurses, and hospitals are paid from

the social-security fund according to pre-arranged schedules.

Medical care—known as medical benefits—was introduced on March 1, 1941, and is defined as covering the services of a physician (including emergency cases, but excluding maternity cases, the administration of anesthetics, and services requiring special skill and experience). The physicians are paid from the social-security fund on a per capita basis. They are also reimbursed for their travel expenses. The person desiring medical benefits fills out an application form and presents it to the medical officer of health in his district. On receipt of the application form, the medical officer issues to the applicant a card which constitutes evidence of the person's right to medical benefits from the physician named in the card.

A list of each physician's patients is kept by the district medical officer. The patient has a right to change physicians, and the physician may terminate any agreement for services made with a patient by notifying the medical officer, who is required to inform the patient accordingly. In order to safeguard a person in need of treatment, the patient's name is not removed from the physician's list until he has been accepted by another physician. The physicians undertaking to provide medical benefits are required to maintain suitable offices, to be available for consultation and treatment at regular times, to visit patients who are unable to come to the physician's office, to prescribe the necessary medicines and appliances, to issue free of charge such medical certificates as may be required, to answer all reasonable inquiries made by the public-health officer, and in general to comply with the regulations governing the medical benefits.

The hospital benefits provided under the Social Security Act consist of hospitalization and out-patient treatment. The hospitalization benefits, including medical and surgical treatment, nursing care, and maintenance in all public and some private hospitals, became operative in July 1939. The provision for out-patient treatment in hospitals went into effect in March 1941. This includes all medical, surgical, and other treatment in hospitals, except dental

treatment, laboratory services, and X-ray services for the purpose of diagnosis and is limited for the present to public hospitals. The hospitals are paid for the treatment from the social-security fund. In order to obtain hospital treatment the patient or his authorized representative must apply to the hospital authorities and furnish any certificate that may be necessary.

Pharmaceutical benefits were inaugurated in May 1941. By contracts between owners of licensed pharmacies and the Minister of Health the former undertake to supply medicines, drugs, and other pharmaceutical material prescribed by a physician or midwife to persons entitled to them. This service, like all others under the Social Security Act, is free to all regular residents of New Zealand, irrespective of economic status, race, or nationality. Payments for the medicines and other material so furnished are made from the social-security fund.

Arrangements are being made for additional benefits, including specialists' services and dental services.¹⁶

3. *Union of South Africa.*—The Factories Law of 1941 applies to many kinds of industrial establishments in the Union of South Africa that were not included in the law of 1918 amended in 1931. Greater safeguards for the

workers' welfare are found in the new law. For example, the minimum age for employment is raised to 15 years in accordance with the revised draft convention adopted in 1937 by the International Labor Conference, whereas in the previous law the inspector was authorized to permit under certain conditions the employment of children 12 years of age, although the basic minimum age for employment was 14 years. A paid annual vacation of 2 weeks is also provided for under the new law. Workers' health is given more consideration than previously. An inspector having reason to suspect that a worker, because of physical defect or illness, is endangering his own health or safety or those of others, may require the worker to present himself for a medical examination at a time and place fixed by the inspector, who, on the advice of a medical officer, may prohibit his employment indefinitely, or for a specified period, or under specified conditions.

A further measure of labor protection in the act is the authorization given to the Minister of Labor to prohibit for specified establishments the giving out of industrial home work of specified kinds.

By the Governor General's proclamation of August 18, 1941, the law became operative on September 1 of that year.¹⁷

¹⁶ Information issued by the Department of Health of New Zealand, May 15, 1941.

¹⁷ *Union of South Africa Government Gazette*, extraordinary issue, April 17, 1941; also issue of August 22, 1941.

BOOK NOTES

THE LAW RELATING TO CHILD WELFARE AFFILIATIONS AND ADOPTIONS, with annotations by John Charles Litherland. Law Book Co. of Australasia, Sydney, Australia, 1940. 380 pp.

This is a comprehensive report of the New South Wales Child Welfare Act passed in 1939. It contains much of interest and value to students of legislation. In addition to the annotated act, which covers a wide variety of subjects, the volume includes the rules, regulations, and forms used in connection with the administration of the act. More than 300 judicial opinions are cited, many of which have been summarized.

THE CANADIAN MOTHER AND CHILD, by Ernest Couture, M. D. Published by authority of the Hon. Ian A. MacKenzie, Minister of Pensions and National Health, Ottawa, Canada. 231 pp.

The Child and Maternal Hygiene Division of the Department of Pensions and National Health of Canada has published recently a book for mothers on the hygiene of pregnancy and the care of both mother and baby during the first year after birth. The book consists of four approximately equal parts in which are discussed the care of the expectant mother, the care and preparation for the actual birth, the care of the newborn baby, and the care of the baby during his first year.

Throughout the book many practical details are given on such things as diet plans accompanied by recipes to suggest ways of using larger amounts of milk, cheese, and vegetables. There are plans for making clothing for both mother and baby, including directions for a number of knitted articles.

Techniques in caring for the baby are simply described and in many cases illustrated with line drawings or with photographs.

A chapter is devoted to the care of the premature baby.

D. V. W.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

LIFE AND WAYS OF THE TWO-YEAR-OLD; A TEACHER'S STUDY, by Louise P. Woodcock. E. P. Dutton & Co., 1941. 267 pp. \$2.

The quality of "being 2" is, according to Mrs. Woodcock, a quality which those having much to do with young children learn to appreciate and to distinguish quite clearly from the quality of "being 4" or "being 5." Two-year-olds have a pattern of behavior that is characteristic of their stage of development, and it is predictable and understandable.

In physical appearance the 2-year-old shows characteristics of his stage of development. "He is rapidly losing the typical proportions of babyhood. He is lengthening in trunk and leg so that his head no longer seems disproportionately large. His figure is coming to be more childlike than babylike."

In kinds of acting 2-year-olds also show their "twoness." "Certain arrangements of their physical environment serve as unfailing stimuli to their activity. Steps or rungs inspire him to climb, inclines invite him to proceed up on foot or on hands and knees, apertures invariably draw them into their depths, and the sight of a tunnel assures their prompt traversing it from entrance to exit and back and forth again and again." In fears and joys, and likes and dislikes the 2-year-olds show a similarity of developmental expression.

But withal their general quality of "twoness," the 2-year-olds are not images of one another; each has a well-marked personality. "As a day-by-day companion in their communal school living," says Mrs. Woodcock, "each 2-year-old stands alone, a vital, distinct, unique young personality, whose differences from his fellows are many and wide and clearly marked." As clearly marked as those of his parents.

The book is rich in illustrative material. Mrs. Woodcock's 9 years' experience in teaching 2-year-olds has given her a rich background of material and deep in-

sight into the elusive qualities of childhood. She uses literally hundreds of examples of behavior—acting, feeling, talking, even sleeping and eating, that illustrate her recurrent point, that although all 2-year-olds share the particular qualities of their stage of maturity each one is nonetheless, for the discerning eye, a personality as definite and as unique as that of the adult he will some day be.

D. V. W.

PUBLIC HEALTH AND HYGIENE, by Charles Frederick Boldrin, M. D. Third edition. W. B. Saunders Co., Philadelphia, 1941. 366 pp. \$3.

Public Health and Hygiene is a comprehensive, concise manual on communicable diseases, community hygiene, and public-health administration. The first 31 pages (part 1) review the development of medicine from Biblical times to the present. Then follows discussion of micro-organisms in relation to diseases, noncommunicable diseases, principles of nutrition, and social and economic factors of public health.

Parts 2 and 3 are occupied with communicable diseases and important noncommunicable conditions, including abnormal mental states, disorders of nutrition, allergies, and endocrine disturbances. The last two sections deal with basic community hygiene services and with public-health administration by Federal, State, and local Government agencies. The last chapter presents evidence of the value of public-health service as an investment.

Included in the new material of this third edition of the book are discussions of air-conditioning, school medical inspection, infantile paralysis, and the influence of the Federal Government in public health.

The book is intended for the use of students of public health, for college students, graduate nurses, and all types of public-health workers.

C. E. H.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Day Care of Children

Day care for young children whose mothers are employed is emerging as one of the urgent social needs of the defense period.

In recognition of the problem the Conference on Day Care of Children of Working Mothers was called by the Children's Bureau and met on July 31 and August 1, 1941, to discuss this entire question and to consider the impact of the defense program in relation to it. This conference adopted a statement of principles and recommended the appointment of several continuing committees (see *The Child*, August 1941, pp. 31-32).

To plan and coordinate all Federal programs involving community provision for the day care of children a Joint Planning Board on the Day Care of Children has been formed, pursuant to one of the recommendations of the conference, by the Children's Bureau, U. S. Department of Labor; the Office of Education, Federal Security Agency; and the Work Projects Administration, Federal Works Agency.

On October 3 and 4, 1941, the various committees appointed as a result of the conference recommendations met in Washington for discussions that developed the following points:

That every community program of day care for children should be founded on careful study and analysis of community needs and resources.

That parents should participate in the planning of day-care programs for their children, which should take into full account the resources for care that might

be provided by the parents themselves through cooperative arrangements, under proper safeguards.

That individual counseling service should be provided as part of the community program.

That special attention should be given to the needs of children of working mothers and children in defense areas living in overcrowded homes or undesirable surroundings.

That plans should be adapted to the varying needs of all age groups under 16 years.

That all day-care programs should be carried on by those who understand children, and should emphasize the importance of considering each child as a member of a family group and of serving his emotional needs and intellectual growth.

That adequate standards of physical care, health protection, and nutrition should be maintained.

That day-care programs should be conducted if possible under the auspices of some recognized agency in the community and should be under the supervision of some unit of government.

At the meeting on October 4 the executive committee of the Committee on Day Care of Children of Working Mothers pointed out that "the time has come when consideration of the entire problem of day care of children ought to be put on a more permanent basis" and recommended to the Children's Bureau the appointment of an "Advisory Committee on Day Care of Children, such advisory committee to be in the same category as other advisory committees of the Bureau."

The Secretary of Labor has approved the appointment of such an advisory committee to the Children's Bureau.

BOOK NOTES

New social-welfare newspaper in Vermont The Vermont Catholic Charities, Inc., has begun the publication of a newspaper, The Vermont Catholic Review, to interpret the various aspects of the social-welfare program to the public. Volume 1, No. 1, under date of August 1941 (Burlington, Vt., 12 pp.) contains articles and news items on a variety of services, including adoption procedures of the diocesan bureau, central-bureau services, and foster-home services.

* * * *

ORGANIZING A PUBLIC WELFARE COMMITTEE IN SPRING COUNTY, edited by Margaret F. Byington. Published for New York School of Social Work by Columbia University Press. New York, 1941. 82 pp. \$75.

This is a brief study prepared by instructors in community organization at the New York School of Social Work with the primary purpose in view of utilizing the study for the training of students in methods of technique for organizing citizen participation in community affairs.

The great impetus given to citizen participation through the citizen committees organized by the Federal Emergency Relief Administration in 1933 and 1934 has stimulated considerable literature on public-welfare boards and citizen participation in public-welfare activities during the past few years. There had, however, been few "case studies" of the methods or techniques of organizing citizen participation and specific analysis of actual events in actual situations. This study presents a step-by-step record of the problems involved. It is organized in two parts. The first part, *Organization of a Public Welfare Committee*, discusses the problems of getting the committee organized in "Spring County" of New York State. The second part of the study, *Social Study as Focus for Development of Public Welfare Committee*, presents a chronological record of the use of the social study as an instrument for the development of the committee's own work and its orientation to community problems.

The entire study should be very useful for teaching purposes as well as for those persons engaged in the organization of public-welfare boards and committees.

RURAL PUBLIC WELFARE; SELECTED RECORDS, by Grace Browning. University of Chicago Press, Chicago 1941. 578 pp. \$4.

The growth of federally financed public-welfare programs, reaching as they do into the rural as well as

urban areas, has resulted in considerable thought and attention being given to the problems of community organization and public-welfare administration in rural areas. This book presents case records from rural public-welfare agencies. The records presented emphasize child-welfare programs, this emphasis being intentional on the part of the author, who found that child-welfare services had made it possible for the child-welfare workers to develop more adequate records. Part 1, *Government and Public Welfare in the Rural Community*, contains two community records with an introduction discussing the extension of public welfare to rural communities and the problems of public welfare as related to rural local governments. Part 2, *Worker, Client, and Community*, begins with a discussion of the relationship of rural culture to social case work and presents 9 case records, most of them problems with primary focus on the child. Part 3, *Rural Social Resources*, discusses local, State, and Federal resources available in rural areas and presents 16 case records. A selected bibliography at the end of the book will be found useful.

Although the book is designed primarily for teaching purposes, workers in public-welfare agencies in rural communities will find the case records provocative and valuable.

C. I. S.

MENTAL HEALTH IN THE CLASSROOM. Thirteenth Yearbook, Department of Supervisors and Directors of Instruction, National Education Association. Washington, 1940. 304 pp. \$2.

The point of view expressed by the editors of the yearbook is that "a more thorough understanding of normal mental health will give insights to teachers which will facilitate the discovery of abnormal behavior. Such an understanding will lead the educator and parent, it is hoped, to refer abnormal cases to specialists for diagnosis and treatment. It is believed that the teacher's emphasis properly is upon the guidance of wholesome growth and the *prevention* of extreme aberrations."

The contributors consider concepts in mental hygiene, factors which contribute to mental health, the emotional growth and mental development of the child, and relationships between the home, school, community, and the child. Descriptions of specific school situations in which mental-hygiene practices have been found to foster mental health and growth are given by teachers, administrators, and supervisors.

The problem of promoting mental hygiene among teachers, through pre-service and in-service training, is recognized. "If teachers are to exert a wholesome

influence on children in the classroom, significant changes will have to be made in pre-service training. Fundamental to all efforts for a teacher-training that recognizes the place of mental hygiene is acceptance of a new kind of education—new at least in contrast to the conventional schooling of the late nineteenth and early twentieth century—that refuses to limit educational programs to the three R's, but rather seeks to affect the lives of individual human beings in every

aspect of human living, emotionally as well as intellectually."

The book contains two annotated bibliographies: The first includes references to the problems encountered by the child in relationship to his family; the second emphasizes the child's problems in development outside the home—in school, on the playground, and in the community.

D. H. F.

• EVENTS OF CURRENT INTEREST •

Army Directive on Children Entering Army Camps for Street Trading

The Adjutant General's Office of the War Department issued a directive order on August 16, 1941, that defines the responsibility of camp and post commanders for the welfare of boys and girls who come into the camps for street trading or other purposes. This directive order states:

1. Reports have been received in the War Department that in some camps and stations young boys and girls are engaged in the sale and distribution of merchandise and newspapers in a manner which has interfered in the past with their school attendance. Similar reports indicate that there has been a lack of proper control over younger persons who have entered the camps unaccompanied by responsible persons.

2. The welfare of such personnel while on the post, camp or station, is a responsibility of the commander thereof, and appropriate steps should be taken to properly regulate their activities. Where applicable, the regulation of these activities should be in accord with Federal and State laws, and local municipal ordinances relating to child labor.

Recent Children's Bureau Publications

THE COMMUNITY WELFARE PICTURE IN 34 URBAN AREAS, 1940; A SUMMARY OF EXPENDITURES FOR HEALTH AND WELFARE ACTIVITIES AND OF REPORTS OF CASES DEALT WITH IN THE FIELDS OF RELIEF AND CHILD CARE. Washington, 1941. 42 plus xlv pp. Processed. This study follows the pattern of a similar report issued 2 years ago. Its principal objective is to provide through the statistics of expenditures and services an over-all view of health and welfare activities in a number of large urban areas.

SERVICES FOR CRIPPLED CHILDREN UNDER THE SOCIAL SECURITY ACT; DEVELOPMENT OF PROGRAM, 1936-39. Bureau Publication No. 258, Washington, 1941. 95 pp. Under development of program are described the organization of State agencies, registration of crippled children, admission procedure, procedure of conducting a clinic, services for children not in need of hospitalization, hospital care, aftercare, quality of service, the distribution of children on State registers by sex, age, race, and principal types of diagnoses, limitations of the program, and advances to be sought. A section giving State summaries of progress is included in the report.

THE YOUNGEST WORKERS IN AN URBAN COMMUNITY, ELIZABETH, N. J. Preliminary report, prepared by Janet H. Lewis. Washington, 1941. 22 pp. Mimeographed. The survey in Elizabeth was part of a larger survey made by the Industrial Division of the Children's Bureau among out-of-school youth under 18 years of age, which covered Tulsa, Okla., and Richmond, Va., in addition to Elizabeth, N. J.

OCCUPATIONAL HAZARDS TO YOUNG WORKERS. Report No. 2, Motor Vehicle Drivers and Helpers. Bureau Publication No. 274. Washington, 1941. 20 pp. This is a report of the second investigation of a series conducted by the Children's Bureau to determine occupations that are particularly hazardous for young workers and therefore subject to an 18 year minimum-age standard under the Fair Labor Standards Act of 1938. It contains data on the extent of employment of minors on motor vehicles, nature and hazards of the work, statistics on motor-vehicle accidents, minimum-age standards, and conclusions.

US EN SU MESA COMIDAS CORRECTAS. This is a Spanish translation prepared for the Department of Public Health of the State of New Mexico of the folder Eat the Right Food, published by the Bureau of Home Economics, with the cooperation of the Children's Bureau and the Office of Education.

CONFERENCE CALENDAR

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|------------|--|--------------------|--|
| Nov. 9-15 | American Education Week. Information and material from National Education Association, 1201 Sixteenth Street NW., Washington. | Dec. 27-30 | American Economic Association, New York. Secretary: James W. Bell, Northwestern University, Evanston, Ill. |
| Nov. 11-14 | Southern Medical Association, St. Louis, Mo. | Dec. 27-30 | American Statistical Association. One hundred and third Annual Meeting, New York City. Secretary: R. L. Funkhouser, 1626 K Street NW., Washington, D. C. |
| Nov. 12-14 | Eighth National Conference on Labor Legislation, Washington. Called by the Secretary of Labor. | Dec. 29-31 | National Conference on Family Relations. Fourth annual meeting, New York. Permanent headquarters: 1126 E. Fifty-ninth Street, Chicago, Ill. |
| Nov. 14 | Child Study Association of America. Institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York. | Dec. 28-30 | American Society for Public Administration. Second annual meeting, Chicago. Permanent headquarters: 1313 E. Sixtieth Street, Chicago, Ill. |
| Dec. 4-6 | National Society for Prevention of Blindness. Annual meeting, New York. Permanent headquarters: 1790 Broadway, New York. | 1942
April 6-10 | Second American Congress on Obstetrics and Gynecology, St. Louis, Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago, Ill. |
| Dec. 12-14 | American Public Welfare Association. Sixth annual round table, Washington, D. C. | May 2-9 | Eighth Pan American Child Congress, Washington, D. C. (Postponed from March.) |
| Dec. 27-29 | American Sociological Society. Annual meeting, New York. Secretary: Harold A. Phelps, University of Pittsburgh. | | |

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

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the

CHILD

*** Monthly Bulletin ***



CHILD WITH POLIOMYELITIS RECEIVING FOLLOW-UP CARE FROM PHYSIOTHERAPIST

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

NOV. DEC. 1911



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

Opportunities for Volunteers in Child Health and Welfare¹

By MARTHA M. ELIOT, M. D.

Associate Chief, Children's Bureau, U. S. Department of Labor

NATIONAL women's organizations have been telling us for 40 years that the welfare of children is of paramount importance to the Nation. The dangers that the world faces today make us realize that conservation of child life in the United States is part and parcel of the defense of our democracy. Our standards of individual care for children, our concern that every child shall be protected with health and welfare services, and the current disruption of community and family life resulting from defense activities make it imperative that we use to the fullest advantage the skill of our all-too-limited numbers of professional workers in these fields. Those who have free time at their disposal perform a signal public service when they make possible expanded services for children by equipping themselves to aid in programs for their care. There is a continuing job to be done by volunteers for children.

Opportunities for volunteer participation in child health and welfare work in this period of national defense are of two kinds: First, the voluntary assistance that must be given by citizens in the initiation, development, and support of necessary community services and facilities for children in military or industrial defense areas and in those regions that might become reception areas for evacuated children in time

of acute emergency; and, second, the day-by-day help that may be given by individuals in providing the health and welfare services and the care needed by children everywhere. In the manual for volunteers on child care² prepared by the Children's Bureau, which is soon to be published by the Office of Civilian Defense, detailed lists will be found of the kinds of work that can be undertaken by volunteers in agencies rendering child-health or child-welfare service, in children's hospitals and clinics, in nursery schools and day nurseries, in family-life education activities, home-economic and housekeeper-aide services, or in other agencies where a general knowledge of child care is needed. They include specific jobs in child-health conferences and clinics, school medical services, school-lunch programs, public-health-nursing services, nutrition classes, mothers' classes, nursery schools, day nurseries, child-caring or child-placing institutions, playgrounds, social settlements, boys' and girls' clubs, and many other agencies.

There is increasing recognition today that the provision of health and welfare services for children must be a part of our national planning

² The term "child care" will be used broadly to cover care of individual children and the community organization necessary to make such care effective. It will be interpreted to include (1) growth and development, (2) daily care and training based on developmental needs, (3) routine activities such as play and recreation, (4) medical and other health services, and (5) social services.

¹ Address presented at the Conference on Women's Activities in Civilian Defense, Washington, D. C., November 8, 1941.

for defense, but the fact that these services are not universally available and that small cities and towns and rural areas are the least well provided for is not sufficiently appreciated. The defense situation is bringing to light the lacks of many small communities and the inadequacies of the child-health and child-welfare programs even in larger places.

There is at this time a great shortage of child-health and child-welfare professional workers that cannot be met for some time to come with existing educational and training facilities. However, the needs of children in the defense areas and in the rest of the country could be met more adequately than at present if, while we await the training and employment of professional workers, a plan of volunteer participation could be worked out and if adequate supervision and guidance could be given by the professional workers now available.

May I illustrate the situation that exists in many defense areas today by excerpts from a recent report from the health officer in a State in the south-central part of the country, a State in which real effort has been made to meet defense needs but which is handicapped by lack of funds and personnel and in other ways. The report reads in part as follows:

The greatest problem at this time is in a military area—an Army post situated in X County near the town of L. The population of the town L has increased from 16,000 to 25,000; the population of the county, from 40,000 to 100,000. The county covers more than a thousand square miles of territory.

As the population increased, the active practicing physicians in L decreased from 14 to 12, or to a ratio of 1 physician to 7,000 people for the county. As would be expected, the shifting population resulted in many problems affecting health directly or indirectly; namely, increases in rent; very poor housing, especially at the outskirts of the city; increases in venereal disease, prostitution, and illegitimacy; overcrowding of the schools; increase in communicable disease.

The report goes on to say that the State health department "has now established a county health unit in this county, providing 1 health officer, 4 sanitarians, and 4 public-health nurses." This means that there is now 1 nurse for every 25,000 persons in the population, but to provide even the minimum number of nurses that would be considered acceptable, that is, 1

for every 5,000 persons, 20 nurses would be needed instead of 4; to provide a really adequate number, 40 would be needed for the present population of this county. The report further explains that child-health clinics with a physician in charge have now been established at four points in the county, each to be held once a month, and that it is planned to provide school medical services throughout the county under the auspices of the health department.

The health officer stated that two defense establishments are now proposed in addition to the one described. One is to be an Army cantonment in Y County that will include up to 45,000 men; the second, a \$52,000,000 powder plant in Z County. This county now has a population of 21,000. The powder plant will be situated near the town of C, a community of 500 people. It is estimated that this powder plant will soon employ between 6,000 and 10,000 civilian workers. At present there is one 75-year-old physician in this county and there are no hospital facilities. The nearest hospital of any size is 40 miles away; there is 1 hospital 27 miles away, but it has only 32 beds and 4 bassinets.

Still more recently a Children's Bureau field worker made the following report:

The A Company is constructing a powder plant, a TNT plant, and a bag-loading plant in an area 8 to 18 miles from the town of X.

This town had originally a population of 900, but the present population is estimated to be around 8,000. The school population has increased to more than 4 times the normal enrollment since April. There are 10 district trailer units within a radius of 8 miles of X, and 5 new ones have been established at distances of 10 to 25 miles from the town. No count has been made of the actual number of families, but it is estimated that there are 250 children of preschool age for a nursery school that can accommodate only 25 to 30. Family life is complicated because some men work on night shifts and have to sleep in the daytime.

To meet part of this need the Federal consultant has suggested that a program of volunteer participation be developed including parent education and the formation of parent councils, organization of social activities, establishment of new playgrounds, classes in sewing and nutrition, and volunteer assistance to the public-health nurse and in child-health clinics.

The situations described by these workers can be duplicated many times. There are at present somewhere in the neighborhood of 400 major defense areas. Some of these are military, some industrial, others shipbuilding areas. Practically every one is having an unfortunate effect on the health and welfare of children in a wide territory, sometimes extending over as many as 10 to 12 counties. These defense areas, as is well known, are concentrated largely in the coastal States and in the northeastern and central industrial States. There is no State, however, without at least one defense area. One southern State has a major defense activity in each of 25 counties.

The problems that result are obvious. One is the migration of families with all the concomitant hazards to the health and welfare of children. Another is the rapid population increase in the defense areas which results in serious crowding and other housing problems. The fact that Federal housing projects have been approved for 478 defense areas is some indication of the urgency of need. Trailer camps are found everywhere on the fringes of the defense areas. It is not necessary to describe what life in a trailer camp means to children or to their mothers when a one-room trailer becomes their only family dwelling place.

The mushroom growth of tiny villages and towns into bustling cities almost overnight carries with it even worse implications, for it has been impossible for the child-health and child-welfare services of nurses, physicians, and social workers to keep pace with the growth of the towns, nor are there sufficient school or recreation facilities. Children are often footloose and subject to exploitation of many kinds in these defense areas. Some have entered industry before the legal age; some young children have been exploited by commercial firms in street trades; petty stealing and other delinquencies are increasing. More child-welfare workers are urgently needed to help meet these social needs of children.

Health conditions for infants and young children are often serious. Many of the defense establishments have been located in counties

where there are no full-time health units, no child-health conferences, no prenatal clinics, no public-health nurses. Often one public-health nurse, already faced with a case load far too great to permit good work, is suddenly overwhelmed with an enormous increase in families—practically all of whom need her help at once because of the inadequacies of their living arrangements and their need for advice about the health of the children or the pregnant mother.

Facilities for maternity care are utterly inadequate in many of the defense areas. Because of a shortage of physicians women are being delivered by untrained midwives; because of a shortage or lack of hospital facilities women are being delivered at home, sometimes under very bad conditions—even in trailers. City and county public hospitals, short of beds and nurses, are finding themselves wholly unable to handle the load of maternity patients. Nurseries for newborn infants are greatly overcrowded. Women are sent home within 3 or 4 days or, sometimes, even within 24 hours after delivery with little or no assurance that a public-health nurse will be able to visit them. Add to all this the withdrawal of physicians from the civilian population to enter the Army or Navy and the situation becomes still more difficult.

Recently another problem has been rearing its head. In many industrial cities we are now confronted with the problem of the daytime (or sometimes nighttime) care of children whose mothers are working in the defense industries. The health supervision and daily care of children in day nurseries and nursery schools, in recreation centers for school children, in play schools and social settlements, must receive increasing attention. Reports now show that day nurseries are overcrowded and are being pressed to take in even more children and so to lower standards of care further. There is even now a shortage of professional workers to staff additional day nurseries and nursery schools.

During this past year the State health and welfare departments have stretched their maternal and child-health funds and their child-welfare funds to meet some of the most

acute needs, but compared with the real size of the problem the provision made is very small. Health and welfare officials have not felt justified in taking away service from a nondefense area that still needs it to help a defense area. Even with money available, the shortage of trained personnel makes quick response to need impossible.

I have dwelt on the needs of these special defense areas because of the acuteness of some of the problems, but I should not want to leave the impression that all is well with children in the towns and rural areas outside the defense areas, for the need is very urgent in many other communities. In only about one-fifth of the 2,400 rural counties have public-health authorities made child-health conferences and prenatal clinics regularly available. In less than one-fourth of the rural counties is there a social worker especially equipped to render child-welfare services.

Large cities are generally fairly well provided with health and medical services for children. But of the smaller cities (10,000 to 25,000 population) one-fourth have no child-health-clinic conferences, and nearly one-half have no prenatal clinics. School medical services nearly everywhere, and especially perhaps in small cities and rural areas, need to be greatly strengthened. Only 2 percent of cities with less than 10,000 population have a hospital out-patient clinic for sick children, and yet half of our children live in these small cities or in the rural areas.

In the light of all this, we may well ask ourselves whether we are providing adequately for the children in our democracy. Obviously we have not yet completed even a basic network of health and welfare services for children in the counties and cities in the United States. We have no universal backlog of maternity and child-welfare service such as that which Great Britain established after the war of 1914-18. We in the United States cannot yet say, as can the health authorities in England, that mothers, even in rural counties, practically never need to go more than 6 or 7 miles to find a child-health clinic.

If this country should be faced suddenly with even more serious defense situations than exist today and if we were forced, as we may be, to provide special protective services for children in areas of military danger or to evacuate children and mothers from certain areas because of potential or actual danger, we should be confronted with a task for which we are clearly ill prepared. The deficiencies in child health and welfare services and the shortage of professional personnel in the smaller towns and cities would suddenly become high-lighted as crucial defense problems, because these are the communities to which many children from the large cities would have to be sent.

There is no need to press the point further to show the need for action in providing more adequate service for children, or the desirability of recruiting and developing a corps of volunteers to assist with the present program, to stand ready in case of still greater need, and to make the time of professional workers more fruitful by aiding them with nontechnical tasks.

I have spoken of two types of volunteers—those who will be responsible for stimulating and initiating and supporting public action for the care and protection of children and those who will assist in the day-by-day work of an agency rendering care. In public child-health or welfare programs volunteers have served most often on advisory committees, as special consultants, or as sponsors of the public program, less often as assistants to professional workers in carrying out the program. In private agencies volunteers have very generally given both types of service. Sometimes fully trained professional or clerical workers no longer employed on a paid basis have volunteered to give part-time assistance in a child health or welfare program, and in thousands of cases pediatricians, orthopedic surgeons, and other physicians have given part of their time to community services for children. Through the home-demonstration program of the Extension Service, thousands of women have been trained as volunteer leaders of groups of rural women.

During this period of national defense all types of volunteer participation can be of great

assistance to both public and private agencies serving children. This applies not only to workers in health and social service but also to home economists and those in nursery-school, day-nursery, school-lunch, and family-life education programs. Where there are well-trained professional and clerical workers employed on the basis of competence to maintain a high quality of service in the program of care and to give the necessary supervision, a plan for the development of volunteer participation can readily be worked out. Child-care programs of all types offer opportunities for thousands of volunteers provided the work is properly organized.

Those who have been instrumental in building up our professional child-health and welfare services understand that volunteer service, usually on a part-time basis, will supplement the work of the full-time paid workers and that it cannot replace their service even in defense emergencies. In time of emergency it may become necessary for one full-time professional or clerical worker to supervise and direct the work of a larger number of volunteers than would be thought desirable in normal times, but even under such a plan the principles of supervision, appropriate preparatory training courses, and orientation to the jobs should be maintained.

In some places the volunteer program has been handicapped by a shortage of physicians trained for maternal and child-health work, of public-health nurses, nutritionists, child-welfare workers, nursery-school teachers, home economists, and others who could give professional leadership and supervision to volunteers. Thus, a vicious circle is established, and volunteers who want to help meet obvious needs are restrained from direct service. Volunteer citizen efforts to bring about the establishment of a program of health and welfare services for children must often precede the participation of volunteers in the program of direct service or care.

For both types of volunteer effort a background of knowledge and understanding is necessary. Citizens who are giving their time to stimulate the establishment of community services for children must know what the health and welfare needs of children are, what services

the community should provide, which services are the responsibility of public agencies and which of private organizations, what sort of community organization will fit their locality best, and how existing services need to be supplemented or improved. Volunteers who propose to give a stated number of hours a week to assist professional workers in caring for children will need to have a body of knowledge the details of which will depend on the exact job that they undertake. But even the volunteer who helps with filing in the office of a child-placing agency or weighs babies in a child-health clinic should have some understanding of how his or her job fits into the whole community plan for children.

And so a course, or courses, of training in child care for volunteer workers becomes an essential part of the defense program. The Volunteer Participation staff of the Office of Civilian Defense has asked the Children's Bureau to outline a simple, basic course in child care, leading to a certificate of Child Care Volunteer, to cooperate with the volunteer offices in developing such courses, and to plan for rosters of child-care volunteers to form a child-care volunteer reserve for use in periods of emergency.

In response to this request the Children's Bureau is including in the manual on child care for volunteers suggestions for a basic course in child care and also for a number of additional shorter courses in more specialized fields of direct service or care. A plan is under consideration for the issuance of certificates in recognition of the completion of an adequate course or courses for preparation of child-care volunteers.

The basic course will include suggestions for some 10 to 12 lectures, observation visits to agencies rendering health and welfare services to children, and a period of supervised study and practice in a single agency or in two agencies giving related service. Altogether the candidate for a certificate will be expected to complete about 80 hours of work.

Some modification in the course for child-care volunteers might be made for persons who have already taken the course for volunteer

nurses' aides, since the combined instruction will equip volunteers to assist particularly well in maternity or children's hospitals or clinics, or in the maternal and child-health program of a health department.

Since special courses in recreation and group work with older children and youth will be outlined in other manuals, the courses for child-care volunteers will be directed particularly toward services and care for younger children and will emphasize work in maternal and child-health agencies and in other agencies such as day nurseries, nursery schools, social settlements, and children's institutions, where day-by-day care as well as service by professional workers is part of the program. It will be suggested, therefore, in the manual on child care that the term "child-care volunteer" be applied to volunteers assisting with care of and services to younger children and not be confused with terms applied today to volunteers participating in group work with older boys and girls, as, for instance, "boy scout leader."

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In closing, I should like to refer to the statement, *A Defense Program for the Children of the United States*, recently forwarded by the Children's Bureau to State departments of health, welfare, and labor with a view to focusing the attention of these State agencies and, through them, of local agencies on the needs of children in the defense program. The objectives of a defense program for children are outlined, and the need for cooperative effort of official agencies, private health and welfare agencies, and citizens is pointed out. Citizens who volunteer for service in the defense pro-

gram are urged to give special consideration to the needs of children.

Obviously, our all-too-small corps of professional health and welfare workers for children needs the backing and the assistance of the women and the men of the country who have time to give for community service. Persons who already have a body of experience in volunteer work with children will make it available, it is hoped, to official child-health and child-welfare agencies as well as to private organizations. In turn, they will want the leadership and help of professionally trained workers. Already some State defense councils have appointed committees to concern themselves with the needs of children. State White House Conference Committees on Children in a Democracy are offering their help to State defense councils. Very recently a National Commission for Young Children was established by the National Association for Nursery Education, and its services have been offered to the Office of Civilian Defense.

To help focus the attention of State and local defense councils on the needs of children should be one of the primary tasks of national organizations of women. To help train a great corps of child-care volunteers who will stand ready for new and taxing tasks in case of greater emergency is an equally important undertaking. Through its program of cooperation with the State agencies the Children's Bureau, as requested by the Office of Civilian Defense, will assist in the development of the program of training and assignment of child-care volunteers and to the extent of its resources will make its services available to women's and citizens' organizations in carrying out this program.

State Services for Crippled Children During Epidemics of Acute Poliomyelitis

By A. L. VAN HORN, M. D.

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Poliomyelitis today represents the largest single cause of crippling from orthopedic conditions among children under 21 years of age. According to recent reports¹ received from State agencies, approximately 20 percent of the children listed on State registers are afflicted with poliomyelitis. At least 10 States have encountered epidemics of this disease during the current year, and since 1936, when State services for crippled children were first developed on a Nation-wide basis under the provisions of the Social Security Act, all but about 8 States have experienced epidemics of poliomyelitis. It is apparent therefore that this disease constitutes an important problem, and that while the number of deaths is *never* alarming, there are usually left in the wake of an epidemic a considerable number of crippled children, the majority of whom will eventually if not immediately seek the services of State agencies administering crippled children's programs.

Although with present knowledge there appears to be no effective means of preventing the disease, the crippling deformities which result from it may in large measure be either prevented or minimized. In order to accomplish this desired result, it is essential that the disease be recognized in its earliest stages and treatment instituted without delay. The importance of measures such as are outlined in this paper is generally recognized by all workers in this field and, in fact, these measures constitute the only effective form of therapy for this disease known at the present time. It is therefore clear that if State agencies are to render an effective service in the prevention of the crippling effects of the

disease they must make effective provision for early diagnosis and treatment by qualified physicians and other professional and technical workers.

During the past few years the majority of State agencies administering services for crippled children have had an opportunity to adapt their State programs to meet the special problems which arise during epidemics of poliomyelitis. In many States satisfactory services have been developed to meet these needs while in others there has either been a lack of recognition of the responsibilities to be assumed or a failure on the part of the State agency to bring about an effective adjustment of the State program to meet the situation.

It is for this reason that it seems advisable to consider at this time the responsibilities that State agencies administering services for crippled children should assume during epidemics of poliomyelitis and how State programs may be most effectively carried out during such periods.

All public and private State agencies concerned with the control of poliomyelitis and the care and treatment of those afflicted should confer well in advance of an epidemic to formulate plans whereby the available facilities and services of the various agencies will be clearly understood and the duties and responsibilities to be assumed by each agency may be defined. Through this joint planning an effective plan of coordination of the available facilities and services within the State may be carried out in the best interests of those afflicted with the disease. Without it, there is bound to arise a duplication of effort, a frequent dissipation of essential funds, increased public hysteria, and a general state of confusion.

¹ Unpublished report from State agencies to the Children's Bureau.

In the following consideration of the services which may be rendered by the crippled children's agency, it is assumed that the agency has a staff of qualified professional personnel, including a medical director who is thoroughly acquainted with problems involved during such epidemics, an orthopedic-nursing consultant, a medical-social consultant, and a physical-therapy consultant. If the orthopedic nurses on the State staff are also qualified physical-therapy technicians, it may not be necessary to employ additional personnel in this special field. The agency will also have available the services of qualified orthopedic surgeons and qualified pediatricians. Such personnel should be invited to participate in the joint planning and should be prepared to indicate the type of service which can be rendered in their respective fields.

The crippled children's agency should immediately consider the steps to be taken in adjusting the State program to meet the emergency. Plans for regular clinic services and for the hospitalization of crippled children without emergency needs may have to be curtailed or perhaps even discontinued for a short time in order to utilize all available facilities and services for the care of children with acute poliomyelitis. Hospitals in epidemic areas should be canvassed in order to discover those which are prepared to accept acute cases of the disease and which are adequately equipped to provide the necessary services. It is important to know which hospitals have respirators and the total number of respirators available in the State.

Hospital authorities who indicate an unwillingness to accept children with poliomyelitis should be apprised of their public responsibilities in making available the facilities and services of their institutions during such epidemics. A ward may be set aside for acute cases, and nurses trained in care of these children may be employed if none are available on a hospital staff.

The agency should also consider the need for augmenting its professional staff especially with reference to orthopedic nurses and physical-therapy technicians. Sources for obtaining additional qualified personnel should be can-

vassed in advance in order to avoid delay in obtaining them when the need arises.

Special consideration should be given to the following problems:

1. Reports of New Cases.

Plans should be worked out between the crippled children's service and the division of communicable disease of the State health department for the crippled children's service to receive prompt notification of all new cases reported to the division of communicable diseases by local health officers or physicians. Frequently the health department may also be given information regarding the extent and severity of the involvement in each patient and whether or not the child is receiving adequate care. If such information is not obtained by the health department as a matter of routine, the crippled children's service should ask for special reports from the local health officer or physician in charge in order that no child in need of care may be neglected during this important initial stage in the disease. The telephone should be used to obtain such information promptly.

It is desirable for the State health department and the crippled children's agency to issue a joint statement to all local health officers and physicians regarding the importance of prompt reporting and of the facilities and services which have been made available by the State agencies for assisting the local physicians and for providing treatment services for children with poliomyelitis. Authoritative bulletins on the early diagnosis of poliomyelitis and the principles to be followed in the care and treatment of afflicted children should be available at the headquarters of the crippled children's services for distribution to physicians whenever an epidemic breaks out. They will find ready acceptance from local physicians. Meetings of local medical societies also offer excellent opportunities for discussing the services provided by the State agency or for the presentation of films dealing with the subject of poliomyelitis. A special program or symposium on the disease can usually be arranged without difficulty at the onset of an epidemic and will be well attended.

Not only should physicians be advised of the importance of prompt reporting but parents should likewise be informed through bulletins and by instructions of public-health nurses of the nature of the disease, the simple precautionary measures to be taken, and the importance of calling a physician with the appearance of any suspicious symptoms. It is usually advisable to keep the public informed regarding the progress of an epidemic by releasing factual data with some reassurance rather than withholding information and permitting rumors and hysteria to prevail.

2. Consultation Services for Local Physicians.

Poliomyelitis is not always easy to diagnose. Experience during some epidemics has shown that in not more than one-half of the cases in which poliomyelitis has been suspected has the diagnosis been confirmed, whereas in other instances it is recognized that many cases are missed. The average physician does not have an opportunity to see many cases of acute poliomyelitis during his practice and often has had little or no special training in the diagnosis of diseases of children. He is, therefore, at a distinct disadvantage in attempting to make an accurate diagnosis in difficult cases.

It is apparent, therefore, that when an epidemic is in progress and diagnostic problems begin to present themselves provision should be made for the consultation services of qualified pediatricians. Requests for such service from the crippled children's agency may be made by the local health officer or the local physicians. Such requests should be acted upon promptly inasmuch as a delay of even a few hours may mean the difference between life and death in a child with bulbar paralysis or one with a spinal type involving the muscles of respiration. If the child has either of these types of paralysis, he will require immediate pediatric and nursing care. If, however, the child has involvement solely of the muscles of his limbs or trunk, which is by far the most common type, he will require expert orthopedic and nursing care as well as general medical supervision, and should be seen promptly in the home by a qualified orthopedist in order that he may advise

regarding the most satisfactory method of treatment. Detailed reports of the examinations, the diagnosis, and recommendations for treatment should be required of all consulting specialists. Once the diagnosis has been made, arrangements should be completed promptly for carrying out the recommendations for treatment.

3. Treatment.

Not all physicians are agreed upon the type of treatment which is most satisfactory for patients with poliomyelitis. However, there is general agreement that complete rest of the affected parts during the acute stage of the disease is of first importance. To accomplish this may require that the child be transported to a hospital immediately, particularly if the need for a respirator or other special treatment facilities is indicated. In many cases hospital care is essential because of the home situation and the obvious lack of facilities to give care to a child with acute poliomyelitis. Nursing care is of such great importance in protecting muscles and continuous medical supervision, in detecting new or advancing paralysis that hospital care is often indicated. The crippled children's agency should be prepared to meet such requests without delay.

Occasionally the child may be satisfactorily cared for in his own home if there are adequate facilities or if they can be made adequate and the parents are sufficiently intelligent. Provision should, of course, be made for adequate medical and nursing care and for supervision by the consulting orthopedist.

Not infrequently children may be satisfactorily cared for in a convalescent home, if the home is prepared to devote its entire facilities and services to the care of children with acute poliomyelitis. However, unless the home has adequate facilities, comparable to those in a hospital, for the isolation of patients, it is inadvisable to house children with this disease with other children.

When children are to be cared for in their own homes without special nurses or in convalescent homes, it is important that the local public-health nurse and the nurses in the convalescent

homes be thoroughly acquainted with the technique of nursing care for poliomyelitis patients. This is a responsibility that may be assumed by the orthopedic nursing consultant on the State staff and may be carried out through instruction classes held at centers throughout the State, by distribution of literature on the subject, by individual bedside instruction, and by provisions for the supervisory or advisory services of district orthopedic-nursing consultants. Not infrequently nurses in hospitals where children with poliomyelitis are under care also wish to take advantage of such instruction and should be invited to attend.

If an agency other than the crippled children's agency has agreed to provide splints or other appliances, plans should be worked out well in advance for the procedures to make such apparatus available to the consulting orthopedist or to the local physician upon the orthopedist's recommendation.

4. Clinics and Follow-Up Services.

With the subsidence of the acute manifestations of the disease the dramatic phases of the poliomyelitis epidemic are over, but the long pull to restore the children to good health and a useful existence begins. Whereas during the acute phase the affected parts of the body are usually kept at rest, the child is now ready to receive regulated exercises, which are usually given by a physical-therapy technician under the supervision of the orthopedic surgeon. This phase of the treatment, which may be continued for a year or more, undoubtedly represents one of the most important therapeutic measures for the restoration of muscle function and power. Plans for carrying out this service should be developed with the greatest of care in order that adequate provision for follow-up treatment will be made for each child.

The child who has been treated in a hospital may be in condition to return to his own home or be transferred either to a convalescent home or a foster home, depending largely upon the extent and severity of the paralysis, the type of daily care and supervision needed, the adequacy of his own home for meeting his special needs, the intelligence of the parents, and so

forth. Such factors must be weighed carefully from both the medical and social aspects and decisions reached which are in the best interest of the child's welfare.

Regardless of where the child is to be cared for, the crippled children's agency should insure adequate supervision and care during this important period. Reports of studies² have shown that the greatest recovery in function and power of affected muscles occurs during the first 18 months after the disease, and that relatively little improvement may be expected after this period. It is imperative that care be given promptly and that follow-up be continuous. Neglect often results in contractures and gross deformities which can only be removed, and then often only partly, by operative procedures.

After the stage of muscle tenderness has subsided and the maximum paralysis has appeared, a careful examination should be made of the neuromuscular system to determine the exact muscles involved and the severity of the paralysis. This may be done either by the attending orthopedist or by a physical-therapy technician working under his general supervision.

Before a child is discharged from the hospital, written detailed recommendations should be given by the orthopedist as to the type of care which the child should receive, with instructions as to orthopedic nursing and physical therapy. Under no circumstances should physical-therapy services be provided for individual children without specific written instructions from the orthopedist. Any services which are to be given by the public-health nurse or other local personnel should be clearly indicated in written instructions transmitted to the local health office prior to or at the time of the discharge of the patient from the hospital. If the local nurse or welfare worker is expected to prepare the home for the return of the child she will need specific information before discharge of the child regarding his condition and any special needs which should be met.

Many of the children returned to their own homes are able to attend periodic follow-up

² Bennett, G. E., and R. E. Lenhard: Treatment of Poliomyelitis in the Paralytic Stage. *International Bulletin* (National Foundation for Infantile Paralysis, 120 Broadway, New York), vol. A40, p. 124.

clinics conducted by the orthopedic surgeon on the staff of the State agency. At these clinics the orthopedist can review the progress which is being made in the care and treatment of the child, recommend any change in therapy, and review the application of casts or adjust appliances. Such clinics should be held in cooperation with local health and welfare personnel and should be so located as to be easily accessible to a large number of the children. If the number attending any one clinic is not large and the quarters are adequate, physical therapy may be given. Often, however, this is not desirable because the space is limited and too many children attend.

Provision for notifying parents of clinic sessions, the place and hour to attend, arrangements for transportation, and so forth, should be carefully worked out by the personnel responsible for organizing the clinic. Great care should be taken in explaining the physician's recommendations to the parents and in instructing them regarding any simple form of massage or passive exercise which the orthopedic surgeon and physical therapist believe can be carried out successfully by the parent.

In some instances, children who are not able to attend clinics may be returned to their own homes. Provision should obviously be made for adequate nursing supervision of these children by public-health nurses under the general supervision of the orthopedic-nursing consultant and by physical-therapy technicians, with periodic examinations by the orthopedic surgeon. The local public-health nurse may be able to give simple physical-therapy treatments under the supervision of the physical-therapy technician or it may be necessary in selected cases for the physical therapist to give such treatments in the home if they require expert services.

Some State agencies arrange for the field or district physical-therapy technician to conduct treatment clinics at strategic localities where a selected group of children may be brought by the parents at stated intervals for physical-therapy treatments. Under such a plan a larger number of children can be given treatments during any one day than would be possible through home visits.

Careful reports should be maintained of the progress made by each child, and these should be kept in the local or district offices with copies in the central office. A periodic review of such reports should be made by the medical director and his staff to determine whether or not every child accepted for care has received the full benefit of the services available for him and, if not, what steps should be taken to improve the services.

* * * * *

The services which have been described above, although not always applicable in every detail, are believed to be based on sound principles which should be observed during epidemics of poliomyelitis. They can be adapted by State agencies to insure the development of adequate services for children afflicted with the disease. If greater care were taken by all public and private agencies concerned with such services in joint planning and in developing an effective coordinated program before an epidemic is in full progress, there would be fewer children left with severe crippling deformities. State agencies administering services for crippled children have an important responsibility to assume in the prevention of crippling among children during epidemics of poliomyelitis. To carry out this responsibility necessary adjustments should be made in the State program in order to meet most effectively the needs of children who contract the disease.

A Day With the State Consultant on Crippled Children's Service

BY CECELIA HEALY ROHRET

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NOTE.—In the process of extending and improving services to crippled children under the provisions of the Social Security Act it is essential that the official State agency develop the services on a State-wide basis. Emphasis is placed on locating and extending treatment to children in rural areas and areas of economic distress. These areas are often those most lacking in health and welfare facilities and personnel essential to the development of a well-rounded program for the treatment and rehabilitation of crippled children.

When the State agency accepts responsibility for medical care for a crippled child it accepts responsibility also for seeing that the child receives in his own community or elsewhere the continuing health and social services that will assure his deriving the greatest possible benefit from the medical treatment rendered to him. Thus, some State public-health nurses and medical-social workers have given direct services to individual children, especially in the more rural States. As local health and welfare services are developed, however, it is possible increasingly to secure these services through local personnel, and the State personnel are able to devote their energies to their primary function of consultation service. In any county where there is a trained case worker or a public-health nurse to render the skilled services essential, the responsibility for service to the child in his home community is carried by the local workers with the cooperation and advice of the State workers.

The following article is an informal review of "a day in the field," as viewed in retrospect by a medical-social consultant in a program of services for crippled children in a rural State. The program in this State includes services to children with rheumatic heart disease as well as those with orthopedic conditions.

Miss James rubbed a patch of frost off the window pane and looked down into a vacant lot near the hotel, advertised on billboards as the best hotel within 50 miles. Discarded automobiles rested on their denuded rims, their hoods and tops covered with snow. Tiny threads of smoke wavered upward from scattered chimneys in the village, proclaiming that the tenants of the houses were beginning a new day.

Picking up a pile of work cards, Miss James slipped them into an envelope and glanced at the map of Iowa lying on the dresser. X's marking the towns on the day's itinerary marched commandingly across its face as if beckoning her to be on her way. As she ate her breakfast, she recalled her notes on the first visit, which she was making to follow up the child's recent discharge from the hospital: Jane Vine, 9 years of age; tuberculosis of the hip; in a cast for 3 months; fourth grade in the village school; rural home. While Jane was still in the hospital Miss James had interpreted her illness to her teacher and to the school principal and had told them of the new device for connecting the room of a crippled child with the schoolroom by a two-way telephone device. They had agreed to have the apparatus set up in Jane's home by the time she returned from the hospital, and had asked Miss James to see, when she made her follow-up call from the hospital, that the device was correctly installed and was being used to advantage.

When Miss James arrived at the Vines' home she was met by Jane's mother. "I am so glad you have come," the mother said, leading the way into Jane's room. The child lay on a single bed looking earnestly at a small radio-like apparatus on the counterpane. She nodded greetings and put her finger to her lips, then pointed to the box.

"Good morning, Jane," said a voice coming from the apparatus.

"Good morning," Jane answered excitedly. "That's my teacher."

"This morning," the teacher began, "we shall open our music class by singing 'God Bless America.'" The singing came in clear and strong and seemed to fill every corner of the sick room.

"I don't hear you singing, Jane. Wouldn't you like to join us?" the teacher's voice came in.

Mrs. Vine began to sing. Jane and Miss James joined her.

When the song ended the shuffling of feet and the giggling and squealing of restless children came into the sick room as plainly as if it had actually been present in the room.

"We'll have 'rithmetic next," Jane confided solemnly as she reached for her prepared lesson. A stillness came into the room similar to that of switching off the radio in one's own home. The apparatus was being carried to the next class. Jane's mother and Miss James went into the living room so that the child could concentrate and be ready to answer questions that the teacher asked her.

Miss James had noticed that Jane's mattress was very lumpy and that the coverings were heavy and ragged. "Have you spoken to the welfare director about bedding?" she asked. Mrs. Vine said that she had, and that she had asked for cod-liver oil and milk, which the doctors recommended, and that the director was now considering the matter. Miss James told her that she would ask the director whether any decision had been reached. She left literature on play equipment and "busy work" for the shut-in and went out to her car.

As she drove down the lane toward the road, she thought over her next visit. Dr. White had written to the State crippled children's service asking what help they could give him with one of his crippled patients. She thought over all the information that she had been able to obtain about Dr. White and wondered how he would receive her. "I hope that he'll at least give me a chance to explain the service," she thought.

Yes, Dr. White was in, the office girl said. "Please be seated." Old people, young children, women with babies in their arms waited their turn. When the doctor had seen the last patient Miss James was told to go in. "Oh, yes," the doctor said as he extended his hand cordially and invited her into his office. "Have you been waiting long?"

"Well, not exactly," Miss James said. "I've been having an interesting time reading and watching your patients come and go. I have come in answer to your letter."

"Yes," he said, "I have a 7-year-old patient, Harold Johnson, out here in the country who

had his leg amputated by a mower. The family is very poor and can't buy an artificial limb, not even a peg. It is awful to see him jumping around on one leg. What can the crippled children's service do to help him?"

"If you will give me permission to go ahead with it," Miss James said, after talking over various possibilities, "I will see what can be done."

When she arose to go, she said, "How is James Williams getting along? You'll remember you sent him up to the hospital 3 months ago. He had chorea."

"I was glad the doctors removed his tonsils and adenoids up there," he replied. "He made a nice recovery. However, 2 weeks ago he had his leg broken. That family has caused me a lot of worry. They're poor, and the mother is to be delivered of her eighth child in a few weeks. She can't give James the care he needs now. I wonder what will become of him while she is ill." Then as if a new thought struck him, he said laughingly, "You think you can work miracles. Perhaps your service can help out here."

"I can't work miracles," she protested, laughing with him. "I can only try to help. Have you talked with your local welfare director or visiting nurse about James and his mother?"

"No; I haven't."

"They might be able to put a Work Projects Administration housekeeper into the home," Miss James offered. "Or perhaps James might be placed in a convalescent home near here."

"I'm afraid I didn't understand," he apologized. "There must be a way to help, but I have been too busy to think of one, I guess."

"If you wish," she offered, "I'll talk with them for you and tell them what you have told me. I feel quite certain some help can be given."

"I'm so glad you have come," he said. "I'll keep your card. Perhaps you can help me again sometime."

Miss James wanted very much to help this doctor. He was the kind of person who would probably find out for himself what this new "service for crippled children" was and, if the service could help him, would use it increasingly.

Miss James looked at her watch as she hurried along to lunch—12:30 o'clock. While she ate her lunch, the ever-present questions ran through her mind. How was she to crowd her new duties into the day and still keep the appointments which she had made with other agencies? Would the welfare director be able to do anything to help Dr. White's patients? Miss James felt that if she failed to find help, Dr. White might lose interest in the crippled children's service, and that is just what she did not want to happen.

By 1:15 p. m. Miss James had her appointment with the welfare director and the visiting nurse. She told them about Harold Johnson and his need for an artificial limb and about James Williams, who had a broken leg and whose mother was unable to care for him properly. The public-welfare department did not have a Work Projects Administration housekeeping service, but the director thought that some way might be found to provide temporary help in the Williams home until after the mother's confinement; he knew also of a nurse in the community who had married and might be willing to take James into her home for convalescent care. It was agreed finally that the welfare director, the medical-social consultant, the doctor, the nurse, and the parents would make a joint plan. Later a plan might be made for convalescent care if that seemed the more satisfactory arrangement. While Miss James was there the public-welfare director telephoned Dr. White for an appointment and was talking in terms of care not only for the boy but for his mother as well.

In regard to the artificial leg for Harold Johnson it was agreed that Miss James would report the situation to the State crippled-children's service and would work out plans for obtaining the needed funds in cooperation with local private groups. Miss James supplied the welfare office with literature on home-made games, play material, and suggested reading. She also gave the director an account of her visit to Jane's home and of Jane's successful use of the telephonic teaching device.

As Miss James was leaving the office the nurse asked, "What can the crippled children's service

do for an intelligent crippled girl 19 years of age who wants to go to business college but whose parents cannot afford to send her?"

"We have no money for educational purposes," Miss James explained. "However, I am glad to tell you that if you write to the State rehabilitation service they can tell you what might be done."

Before she started her car, Miss James looked over the list of calls she had planned for the day. Three more were on the list. It was now 2:15 p. m., and she had 24 miles to drive to the next call.

Bonnie Carnes, a diabetic child, was next. Miss James reread the letter Bonnie's grandmother had written to the hospital. "Bonnie was sent home from school, and I can't do anything about it." As the county in which Bonnie lived had no social-case worker, no child-welfare worker, and no visiting nurse, the State medical-social consultant had been asked to visit Bonnie's home and her school teacher. Miss James hoped Bonnie's offense was not so great as to require more than an interview with the teacher to straighten matters out again.

When she arrived in the home she found Bonnie hanging her bedding over the hot-air register to dry. She was in a very bad temper, but her temper was exceeded by that of the grandmother. The latter immediately launched into a tirade against the school. "They say she is a disturber. They're all afraid of her. They think she's crazy."

"What are they afraid of?" Miss James asked.

"They're afraid she'll have a 'spell,' and they're afraid she might die in a spell. At home she snitches food all the time. She wets the bed every night," and, she rushed on, bursting into tears, "I can't leave my purse around, or she will steal from it. I think I'll have to put her into an orphanage."

"When did all this trouble start?" Miss James asked.

"About 6 weeks ago."

Miss James made quick mental calculations. The trouble at home started about the time of her dismissal from school. Miss James told the grandmother she was sure that matters could

be smoothed out if someone outside the family explained Bonnie's disease to the teacher. Would the grandmother be willing to have her talk with the teacher? Miss James noticed that Bonnie seemed to be holding her breath as she waited for the grandmother's reply.

"It will do no good," the grandmother said. "She is set against us." Bonnie gave a quick jerk at the bedding and almost upset the chair on which it hung. "You can try it if you want," the grandmother added. "I've worn my soul out with them."

Miss James explained that it was part of her job to try to correct misunderstandings and to straighten out difficulties. She would talk with Miss Bain, the teacher, herself, and then return to talk with the grandmother the next day. She invited Bonnie to go out to the car with her to get a children's magazine which she carried with her. The child came reluctantly as if expecting to be scolded.

Miss James disregarded this and told her about the diabetic children whom Bonnie had met while in the hospital. "Are they in school?" Bonnie asked timidly.

"So far as I know, they are," Miss James answered. "Why don't you write to them?" she asked. This was a new thought. Maybe she would.

"I'll be interested to know how you get along. Here's a stamped envelope, if you should like to write to me about it. If you write, tell me all about school, too," she added.

The children were being dismissed from school when Miss James arrived. "I am sorry to be late," she told Miss Bain, "but unexpected things came up today which have delayed me. I've come, as you know, to talk with you about Bonnie Barnes. I wondered what had happened to her."

Miss Bain took the grandmother's letter from her desk. The letter said that Bonnie was very likely to have an insulin shock at any time or to go into a diabetic coma. She listed a number of symptoms that she might show, and told Miss Bain what she might do about them.

Miss Bain explained frankly that she had been so overwhelmed by all these warnings that she had watched Bonnie closely lest something

should happen to her, but that Bonnie took advantage of it. When anything difficult arose, or if she had trouble with her classmates, Bonnie put her head down on the desk and pretended to lose consciousness. The whole class had become so apprehensive about the child that good school work had become impossible. The grandmother was finally advised to keep Bonnie out of school.

"A fine escape mechanism on Bonnie's part," Miss James laughed in amusement, but Miss Bain could see nothing amusing about it.

"I've never known a person with diabetes, and I did not know what to expect," she acknowledged.

Miss James explained the disease in an attempt to clear up the fears which the grandmother's letter had created in Miss Bain's mind. "Bonnie," she told her, "should be as healthy as the average child, or even healthier, because of her well-balanced diet. I don't believe I should be so concerned about her. She can be treated just like any normal child." Miss James then gave the teacher a simple article on diabetes written by a pediatrician and went over it carefully with her.

"I am willing to try again," Miss Bain said, "but the grandmother has become so belligerent that I am afraid she will continue to cause trouble."

"It is too bad that there isn't a child-welfare worker or a nurse or a social worker to act as mediator for you," Miss James hinted.

The teacher's face brightened. "Mrs. Green, one of the officers of our parent-teacher association, was formerly a trained child-welfare worker," she said.

"Perhaps we could get her to work with the grandmother and Bonnie," Miss James responded, trying to keep her voice from showing too much enthusiasm. "Perhaps you would like to have me talk with her."

"I'll call her," the teacher offered, reaching for the telephone. "I think I can make an appointment for you." Mrs. Green was leaving town next morning. Would Miss James care to come to talk with her now?

It was nearly 5 o'clock. Yes; Miss James would be glad to go. She could scarcely keep

from hurrying out of the room to be on her way to Mrs. Green's home. "I'll try to see Bonnie's doctor tomorrow," she promised Miss Bain. "He may want to see the child before she returns to school, or he may want to send her back to the hospital for a complete check-up. I'll either telephone or write you a note after I have seen him."

When Miss James sat down with Mrs. Green and explained the situation, she could see the problem unfolding in her listener's mind.

"It makes me feel like a bound on the hunt again," Mrs. Green said enthusiastically. Yes, she would begin at once to work with the grandmother and Bonnie and make sure that the child returned to school immediately.

Miss James felt that a weight of responsibility had been raised from her shoulders. She wanted to sink back into her comfortable chair and rest for hours. But what was this that Mrs. Green was saying? "Wouldn't you like to go with me to a pot-luck supper that our church group is having this evening? I am sure the ladies would be interested in hearing about the services for crippled children."

Miss James' first thought was to refuse, but her second thought was that this would be a fine opportunity to explain the service to a citizen

group and to find new resources with which to work. Yes, indeed, she would be glad to go.

It was 10:15 p. m. when Miss James reached her hotel room. She removed her hat and coat and spread the road map of Iowa out on the table. As she studied it, she slipped today's unkept appointments into tomorrow's envelope. She said aloud, "Bonnie's doctor—the grandmother—a note to the teacher and a note to Mrs. Green. If I get out of here by noon, I'll be doing well."

No doubt any hospital or clinic could match these incidents, but to the workers with the crippled-children's service they have much significance. The best medical skill falls far short of its realization when social resources are lacking. Yet the consultants are constantly faced with this lack. Recruiting responsible help in some rural communities is a difficult task. The consultant must weigh, constantly, the type of person she approaches for aid against the type of responsibility involved. Sometimes she must spend hours on one case in an effort to find an organization or an interested individual who will understand the needs of the child even to a minor degree. She is keenly aware at all times of the necessity for meeting the needs of the whole child but must be content in many cases if she falls short of this objective.

BOOK NOTES

NUTRITION IN HEALTH AND DISEASE, by Lenna F. Cooper, Edith M. Barber, and Helen S. Mitchell. J. B. Lippincott Co., Philadelphia, 1941. 709 pp. \$3.50.

This latest edition of a familiar textbook has been rearranged to conform to A Curriculum Guide for Schools of Nursing, published by the National League for Nursing Education. These changes, however, have not detracted from its usefulness as a general reference book for nurses in service or for college students. The units dealing with diet in disease have been brought up to date and expanded to include some of the newer dietary procedures. As with the earlier editions, emphasis has been placed on the normal well-balanced diet as a basis for all modifications. The unit on the Feeding of Mother and Child has been revised to "include material based on the publications of the Children's Bureau." In view of the present increased interest in the subject of nutrition

and its relation to good health, the authors have enlarged the section on dietary standards to include a statement on the recommended dietary allowances recommended by the Committee on Food and Nutrition of the National Research Council, and some discussion of dietary standards for the family group. Although the authors state that "the book is written with the needs of the nurse in mind" they believe "that even the busy housewife whose responsibilities to her family involve the planning of menus, the buying of food, as well as the preparation of it, will also find much of value in it."

A PRIMER ON THE PREVENTION OF DEFORMITY IN CHILDHOOD, by Richard Beverly Ramey, M. D., National Society for Crippled Children, Elyria, Ohio, 1941. 188 pp.

This little volume, which has been prepared for the use of family physicians, public-health nurses, and

social workers, should find ready acceptance by the large number of professional personnel who are engaged in health and welfare services for children.

The opening chapter deals with common afflictions of childhood which may cause deformity, such as acute poliomyelitis, cerebral palsy, congenital anomalies, osteomyelitis, tuberculosis of bones and joints, burns, and so forth. Each subject is covered by a simple, clear-cut statement regarding our present knowledge of the nature of the disorder and the measures which should be instituted in order to prevent the disease or deformities resulting from it.

Subsequent chapters deal with the most important deformities encountered in childhood according to the region of the body affected. Under each type of deformity may be found a statement regarding the characteristic features of the deformity, the causes commonly associated with it, and the methods of prevention which should be employed under each type of disorder.

No consideration is given in the discussion of the various types of deformities to problems concerning the social adjustment of the child to his physical handicap. Such problems are frequently of equal or perhaps greater importance than the treatment of the deformity itself.

The book is illustrated by 88 drawings. The combined glossary and index provide for ready reference.

THE CRIPPLED CHILD IN NEW YORK CITY; REPORT OF THE COMMISSION FOR STUDY OF CRIPPLED CHILDREN, Philip D. Wilson, M. D., Chairman. Published by Commission for Study of Crippled Children, 302 Ninth Ave., New York, 1940. 218 pp.

PHYSICALLY HANDICAPPED CHILDREN IN NEW YORK CITY; GENERAL REPORT OF THE COMMITTEE FOR THE STUDY OF THE CARE AND EDUCATION OF PHYSICALLY HANDICAPPED CHILDREN IN THE PUBLIC SCHOOLS OF THE CITY OF NEW YORK. Board of Education, City of New York, 1941. 91 pp.

The Commission for Study of Crippled Children appointed by Mayor LaGuardia in March 1938 was charged with the responsibility for investigating the problem of the crippled child in New York City and for making recommendations in the light of its findings. The report, *The Crippled Child in New York City*, is an excellent presentation of the study made under the auspices of the commission and constitutes the basis for recommendations which have since been incorporated in a coordinated program for crippled children under the city department of health. The commission analyzed information obtained on two groups of crippled children, the first being 16,731 children registered by the commission during the initial period of the survey and the second being a more intensive study of a random sample of 1,277 children representing 7.6 percent of the total.

The report contains material of interest on the enumeration of crippled children, the physical and social status of those registered, facilities and services available for the care and treatment of crippled children, educational facilities, vocational services, and malnutrition. In 1938-39 there were more than 11,000 physically handicapped children receiving instruction in New York City.

The plan of the study, its findings, and the recommendations which emerged should be of interest to all workers in crippled children services, particularly to those in urban areas where there is frequently found to be a need for coordinating existing facilities and services in a manner which will more effectively serve the needs of the crippled child.

Since 1904 the New York City Board of Education has given special consideration to the educational needs of physically handicapped children. Classes have been maintained in hospitals, convalescent homes, and special schools, in addition to provision for the education of home-bound children. These educational programs have been adapted to meet the special needs of children with tuberculosis, orthopedic defects, deafness, defective vision, speech defects, heart disease, and malnutrition. In 1938-39 there were more than 14,000 physically handicapped children receiving instruction in New York City.

That an educational program so intensive deserved careful consideration and review in order to formulate future policies was clearly recognized by the Board of Education. In November 1936 the Board authorized the appointment of the Committee for the Study of the Care and Education of Physically Handicapped Children, to inquire into the care and education of physically handicapped children in the public schools.

In the general report, prepared for the committee by a group of educators and physicians, are considered the problems involved in the light of the past development of the present educational program, the educational objectives, the special consideration favoring modified school programs for the physically handicapped, the various physical, psychological, and social factors involved in adapting the educational program to the individual child, recreational activities, vocational guidance, training and placement, administration and cost of the program, and special problems such as educational progress, transportation of the physically handicapped child, and teaching personnel.

One chapter is devoted to an enumeration and discussion of the inadequacies of the present educational programs for physically handicapped children; the final chapter summarizes the findings of the Committee and the conclusions reached.

This report will be of interest to educators, physicians, public-minded nurses, and social workers who are engaged in services for physically handicapped children.

A. L. V. H.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Need for Action on White House Conference Child-Labor Standards

BY GERTRUDE FOLKS ZIMAND

Associate General Secretary, National Child Labor Committee, New York

Nearly 2 years have passed since the White House Conference on Children in a Democracy adopted a platform of standards as the minimum of child-labor protection which should be accorded to children throughout the Nation. These years have been a period of rapid industrial expansion, with the demand for labor in defense industries creating, in turn, employment opportunities in all sorts of occupations, skilled and unskilled, from which workers have been drawn in large numbers. With more jobs to be had, in many cases at better wages than a few years ago, the young worker under 18 years is once more finding that there is a place for him in the labor market. This is reflected in high-school-enrollment figures which, for the first time in many years, are stationary or dropping, even in production centers where there has been an increase in population.

If the White House Conference standards had become a reality, the increased job opportunities for children and young people would give little cause for concern. We could rest assured that youngsters of 10 and 12 years were not being hired even for part-time work, that children under 16 years were not leaving school for jobs, and that older boys and girls were not employed for unreasonable hours or in occupations which the accident risks render unsuitable for immature workers.

In view of the fact that State laws in general fall short of these standards, the slowness of State legislatures to act upon the White

House Conference standards in the face of the increase in juvenile employment becomes a matter for serious concern. Efforts during the past 2 years to incorporate these standards in State legislation have been, with two or three conspicuous exceptions, fruitless. In fact there have been a number of attempts, some successful, to break down existing standards.



The core of the conference recommendations is a 16-year age minimum for manufacturing occupations or for any employment during school hours. Through the child-labor provisions of the Fair Labor Standards Act of 1938 this standard had been established more than a year before the White House Conference convened, for industries producing goods shipped

in interstate commerce. But there is a vast area of employment which is not interstate and does not come under the Federal law—work in local stores, offices, hotels, filling stations, restaurants, bowling alleys, and so forth. Regula-



tion of child labor in such intrastate industries is dependent upon State legislation. Apart from agriculture and domestic service—where standards notoriously lag—only 11 States¹ had a basic 16-year age minimum for employment in January 1940. Since then 2 more have joined the ranks—New Jersey and Florida. But bills to establish this standard in 7 other States (Arizona, Delaware, Georgia, Maryland, Michigan, North Dakota, and Virginia) were unsuccessful, and in 1 State, Pennsylvania, an effort was made, fortunately unsuccessful, to lower the age for school leaving and employment from 16 to 15 years.

The White House Conference also recommended that the minimum age for work outside of school hours in suitable nonmanufacturing occupations be 14 years. The number of States which even approximated this provision (most have special exemptions or incomplete coverage) had increased from 23 in 1939 to 25 at the end of the 1941 legislative session, the only new States being New Jersey and Florida. Several attempts have been made to lower standards for children working outside of school hours—for pin boys in bowling alleys, golf caddies, and newsboys. Most of these were unsuccessful,

but Indiana did succeed in excluding newspaper carriers from the minimum-age, maximum-hour, night-work, employment-certificate, and physical-examination requirements of the child-labor law. And only by virtue of a gubernatorial veto in California spared the spectacle of 10-year-olds legally selling papers on the streets till 10 p. m.

A point on which the White House Conference was especially emphatic was that the standards recommended should be applied to industrialized agriculture as well as to industry.

"The fact cannot be too strongly emphasized," said the report, "that the work of children in certain phases of agriculture is different today from what it was when children were mainly working for their parents or cooperating in harvesting a neighbor's crops. With the development of intensive cultivation of specialized crops there has grown up the practice of using large numbers of children in industrialized agriculture under conditions which in many instances differ little from those of 'sweatshop' employment and which require the same kind of safeguards as those found necessary with reference to industrial employment."

But the only agricultural "gains" that can be noted during the period since the conference convened are a requirement in California that children employed in industrialized agriculture must have work permits, a Florida law which applies to employment in any gainful occupation with a specific exemption of agricultural work applying only outside school hours, and a New Jersey law which forbids employment during school hours of children under 16 years whether resident or nonresident. The New Jersey law also sets a 12-year age minimum for agricultural employment outside of school hours, with work limited to 10 hours a day. Even this regulation was challenged before it had been in force a year, and a bill to empower the commissioner of labor to suspend the agricultural provisions of the child-labor law is still pending in the legislature.

As to the remaining 45 States, agricultural employment is excluded from the child-labor law either by specific exemption or by its omission from the enumerated occupations covered

¹ One additional State, Montana, had a 16-year age minimum for employment in any factory or where any machinery is operated.

in 21 States; and in 18 States, although a general child-labor provision forbids any employment during school hours, such provisions are not generally enforced for agricultural employment. In the other 6 States (Massachusetts, New York, North Carolina, Ohio, Pennsylvania, and Wisconsin) some attempt is made to regulate child labor in industrialized agriculture through specific legislative provisions. The problem, however, has by no means been solved even in these States. In some of them no standard applies outside of school hours or during vacation, and in others recent reports indicate that little control is exercised over agricultural work in vacation periods.

Other basic features of the White House Conference standards relate to protection for young people legally permitted to work—regulation of hours and night work and prohibition of hazardous employment for minors under 18 years. Provisions along these lines were incorporated in the child-labor-law revisions proposed in the various State legislatures but, except in New Jersey and Florida, were lost along with bills raising the minimum age. Except for the rulings promulgated by the United States Children's Bureau under the Fair Labor Standards Act setting an 18-year age minimum for occupations deemed to be especially hazardous, there have been very few gains in this aspect of child protection. And this despite the fact that young workers especially need such protective legislation at the present time when they are entering industrial plants in increasing numbers.

Equally fundamental are the conference recommendations dealing with employment certificates—the backbone of any child-labor law. Weaknesses in the administration of the certificate system can nullify the whole intent of the law. Much has been accomplished in improving the administration of State child-labor laws through the cooperation of the United States Children's Bureau with the States in the enforcement of the child-labor provisions of the Fair Labor Standards Act. A tightening up of the whole employment-certificate system has taken place. Nevertheless,

the recent demand for workers has rendered enforcement more difficult, and State authorities are reporting increasing numbers of children found working in violation of the law. Thus, the September issue of *Alabama Social Welfare* states:

Child labor has proved a decided problem in counties where most of the adults have good jobs and employers are finding it difficult to hire delivery boys, car hops, and so forth. Children are also pursuing street trades. The Department of Public Welfare is cooperating with the Department of Labor in enforcement of the child-labor law.

And from Ohio comes a report from an inspector of the State Labor Department that many small manufacturers and business proprietors who run amusement places, liquor establishments, restaurants, curb service, and so forth are hiring boys and girls under the mini-



imum age and working those of legal working age longer than is permitted.

The drive for enactment of the White House Conference child-labor standards into law must go on, and at an accelerated pace. The demands of industry and the temptation to children to cut short their schooling when work opportunities are offered are too persuasive to be blocked except through legal regulation.

The choice for the individual child or family between school or employment sometimes seems a difficult one to make, but it would be a most short-sighted policy, from every point of view, if children were permitted to yield to the call

of the job. An editorial widely syndicated among southern newspapers sums it up thus:

During recent vacation months, under stimulus of the defense program, the Nation's youth has become employed in unprecedented numbers. Many youngsters will be loath to quit good-paying jobs to resume their formal education. Employers, faced with contracting labor markets, will wish to keep young employees on their pay rolls. . . .

Child-labor and compulsory-school-attendance legislation plays an indispensable part in making for gen-

erally improved conditions in the United States and should receive the full support and cooperation of employers. While it might appear at the time that both the employer and his youthful employee would benefit by a continuation of the employment contract after school has reopened, ultimately undesirable effects would be felt. The employer would find himself operating a business in a locality where education has been neglected and consequent poverty and backwardness prevailed. The young employee would be unable to better his position and both parties would bog down.

Advisory Committee on Occupations Hazardous For Minors

On November 5, 1941, the Children's Bureau's Advisory Committee on Occupations Hazardous for Minors met to discuss problems arising in connection with the development of hazardous-occupations orders under the Fair Labor Standards Act and to advise the Bureau regarding policies to be followed in meeting them. Matters given particular attention were methods of framing orders where exposure to poisonous substances is involved and the treatment of apprenticeship under hazardous-occupations orders. This meeting of the committee is the first one held since the reconstitution of the committee for a second 2-year term. The members of the committee appointed by the Secretary of Labor in October 1941 are:

Chairman, Cyril Ainsworth, New York, assistant secretary, American Standards Association.

James B. Carey, Washington, D. C., secretary, Congress of Industrial Organizations.

Courtenay Dinwiddie, New York, general secretary, National Child Labor Committee.

Dr. Leonard Greenburg, New York, executive director, Division of Industrial Hygiene, New York State Department of Labor.

Dr. Alice Hamilton, Hadlyme, Conn.

R. McA. Keown, Madison, Wis., engineer, Safety and Sanitation Department, Industrial Commission of Wisconsin.

Dr. S. Z. Levine, New York, Children's Clinic, the Society of the New York Hospital.

C. E. Pettibone, Boston, vice president, American Mutual Liability Insurance Co.

Albert S. Regula, New York, Industrial Relations Counselors, Inc.

Robert J. Watt, Washington, D. C., international labor representative, American Federation of Labor.

Albert W. Whitney, New York, consulting director, National Conservation Bureau.

The following persons have been appointed as Government advisers to the committee:

Max D. Kossoris, statistician, Industrial Injury and Workmen's Compensation Statistics, Bureau of Labor Statistics, United States Department of Labor, Washington, D. C.

Dr. Paul A. Neal, Chief, Research Section, Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service, Federal Security Agency, Bethesda, Md.

Dr. R. R. Sayers, Director, Bureau of Mines, United States Department of the Interior, Washington.

V. A. Zimmer, Director, Division of Labor Standards, United States Department of Labor, Washington.

New Child-Labor Law of Brazil

By ANNA KALET SMITH

Office of the Chief, U. S. Children's Bureau

Protection of working children in Brazil, the subject of a recent law, has been a difficult problem for many years. The first attempt at nation-wide regulation of child labor in that country was made by the Children's Code of 1927,¹ which also initiated other reforms in the field of child welfare. This code prescribed a basic minimum age of 14 years but permitted employment at the age of 12 if the child had a certificate of primary education. Even this requirement, however, could be waived if the child had to support himself or his parents or grandparents. The consequent withdrawal from school of large numbers of young children and their entrance into occupations often harmful to their health or morals have presented serious problems.

With the inauguration of the present Government in Brazil in 1930, child-welfare work entered upon a new era. Among the many steps taken since that time for the improvement of the situation of children was the regulation of child labor in factories and mines by a decree of 1932.² This decree prescribed a general minimum age of 14 years and required, for the employment of a child between 14 and 18 years of age, the presentation to the employer of proof of age, authorization of employment from the parent, a physician's certificate of physical and mental fitness, and proof of literacy. Exemption from the literacy requirement was still permitted in cases of poverty. Five years later the Federal Constitution of 1937 approved the principle of a minimum age of 14 for all employment. It was apparent, however, that numerous abuses remained in the field of child labor and that further action was needed. Early in 1940³ the Government appointed a special commission to study the possibility of improving child-labor

legislation and bringing it up to the standards approved by the Conference of the International Labor Organization. As a result, a new child-labor law regulating the employment of persons under 18 years of age was approved on September 13, 1941.⁴

The influence of the International Labor Organization standards is evident in this law, but certain new features were introduced to meet conditions in Brazil. The law combines to a considerable extent the regulations on non-industrial employment contained in the Children's Code of 1927 with those on industrial employment in the decree of 1932, but raises the standards of both and adds to the effectiveness of enforcement. It applies to both industrial and nonindustrial occupations other than agriculture, exempting domestic service and workshops which employ exclusively members of the child's family and in which the child is under the direction of the father, mother, or guardian. Agricultural work is covered by these provisions only when industrial processes are used, but subsequent regulations are to determine whether or not the law is to be applied to other kinds of farm work.

The minimum age for employment remains 14 years, but in contrast with previous legislation, no exemptions are allowed in case of poverty. The provision for an 8-hour day, the prohibition of overtime and night work for persons under 18, with some exceptions, and prohibition or regulation of employment of minors in dangerous occupations or those harmful to their health or morals—all found in the previous laws—are repeated in the new law. Among the innovations introduced by the new law is the detailed regulation of street trades, long considered a menace to the health and morals of the large numbers of children engaged in them. The Children's Code of 1927 prescribed for such trades a minimum age of

¹ *Collecção das Leis da Republica dos Estados Unidos do Brasil* de 1927, Rio de Janeiro, vol. 2.

² *Diário Oficial*, Rio de Janeiro, November 5, 1932.

³ *Boletim do Ministério do Trabalho, Indústria e Comércio*, Rio de Janeiro, No. 68, 1940.

⁴ *Diário Oficial*, Rio de Janeiro, September 16, 1941.

14 for boys and 18 for unmarried girls and mentioned briefly the need of a permit from the "competent authority." The law of 1941 requires for children between 14 and 18 years of age a permit from the judge of the juvenile court issued only when the work is found to be necessary for the support of the child, his parents, grandparents, brothers, or sisters, and when it will not affect adversely the child's morals. In localities in which officially recognized institutions have been opened for the shelter and care of newsboys, the judge may issue permits only to children living in those institutions.

The requirement of an employment certificate or work-paper (*carteira de trabalho do menor*) for all children between 14 and 18 years of age is another new step toward the protection of the working child in Brazil. To obtain this certificate the child must present not only the four documents which he was required to furnish the employer under the law of 1932 (that is, proof of age, parent's authorization, physician's certificate, and proof of literacy) but also his photograph and a statement from the employer as to the kind of work that the child is to do.

Illiterate children may be given a certificate, valid for 1 year, upon presenting proof of part-time attendance at school. The employer is required to allow the time for such attendance. If at the end of the year the child is still unable to pass the literacy test, he may be given another extension of 1 year, or his certificate may be canceled. The requirement of this test is waived when there is no primary school within a mile; upon the establishment of a school the rule again becomes effective. The form of this certificate is to be determined by the National Department of Labor, Industry, and Commerce,

and it is to be issued in the Federal District, which includes the capital, Rio de Janeiro, by the National Bureau of Labor and in the States by the Department's regional offices. In the absence of such offices, however, employers may employ children without certificates upon presentation of proof of age, physician's certificate, and proof of literacy.

The employer keeps the certificate for the duration of the child's employment and notes on it the wages paid and the dates of beginning and ending of the employment. The certificate must be shown upon request to the labor inspector.

If an inspector finds that the work a child is doing is physically or morally harmful to him, he may require the child to discontinue the work, and it is the duty of the employer in such a case to give the child more suitable employment.

As in the previous legislation, employers and parents are subject to penalties for violations of the law; now, lowering of wages as a consequence of the law is also made a punishable offense, and the parent, in addition to being fined, may be deprived of guardianship over the child if he fails to send an illiterate child to school or if he allows a child to be employed in an occupation prohibited because it is morally harmful.

The law is to be enforced in the Federal District by the National Bureau of Labor; elsewhere by regional offices of the Department of Labor, Industry, and Commerce, or in the absence of such offices, by especially designated officials.

In order to allow the employers and workers sufficient time for adjustment to the new conditions, the law will not go into effect until January 1942, and a period of 1 year is allowed before its application to children employed on the date of publication.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Organization of Social Forces in Small Towns and Rural Communities¹

By RUBY D. ELWELL

Child Welfare Division, State Department of Public Welfare, St. Albans, Vt.

What does the community expect of a child-welfare worker? This is the first question in the mind of a worker going to a community where there have been no social workers. If the community's conception of the worker's function differs too widely from her own, she cannot gain the local cooperation and support on which effective community organization depends. The social worker is fortunate who finds that some interpretation of her function has been given to the community before her arrival and that the townspeople have expressed a desire for her services.

Some areas, such as the rural Vermont county into which I came, are selected for child-welfare services because of the need of the people rather than from any expressed desire on the part of citizens for the service. The people in this county had varying ideas as to the social worker's role. For instance, some, especially overseers of the poor, expected the "State woman" to put the "fear of God" into problem families. On the other hand, those in need either were distrustful and fearful and asked only to be let alone or wanted someone to stand against the powers that threatened to break up their homes. The more thoughtful and socially minded townspeople wanted someone to do preventive work with dependent, neglected, and predelinquent children.

A typical day's requests received by the new worker illustrate this community's conception of the social worker's function:

There is a timid knock at the door. Mrs. N in tears states that her husband, an alcoholic, has run away and that the overseer wants to send her and her five children to the poor farm; can't the worker help her?

Mrs. L telephones from the lake that several girls are going swimming in the nude and wants the worker to stop them.

Mr. C's wife has run away and he wants the worker to bring her back.

Miss M reports that one of her neighbors is starving a pig and she (Miss M) wants something done about it.

Mr. R writes that a neighbor is overworking and abusing a child who was left in his home by the child's father and requests an investigation.

An overseer of the poor stops in to say that Mrs. B, a recipient of aid to dependent children, is spending the money foolishly.

A petition for commitment is received from the court, asking for an investigation of the A home as the children are reported to be stealing.

There seemed to be no limit to what was expected of the social worker. The reason for the variety was, of course, the absence of other agencies. As the worker's function was not understood, it seemed wise to begin by studying the social problems and attitudes of everyone she met. Thus the worker would find out where to start in relating her skills to the needs and in showing the community how she could be most helpful.

Many of the problems were found to center around the system of relief, under which each

¹Paper presented at the National Conference of Social Work, Section on Community Organization, Atlantic City, N. J., June 3, 1941.

town, a comparatively small group of people, is responsible for the care of the needy in its section. The overseer of the poor, forced by public opinion, must make it his major concern to keep down expenses for relief. If a family to whom he has issued a grocery order for a small amount comes back too soon, he may threaten to send the parents to the poor farm and petition for the commitment of the children to the department of public welfare. In many instances families have been allowed to remain for such a long time without adequate assistance that their morale has broken down and the possibility of rehabilitation has become doubtful. Many families whose children suffer because of the need of supplementary income are deterred from applying for assistance by the attitude of the overseers. It is small wonder that the number of children committed for care in this State is twice as great in proportion to its population as that in the United States as a whole.

Attitudes and prejudices that prevent an objective approach to the subject of relief were also found. One attitude is that relief administration is simple, that it is just a question of alternatives—of people helping themselves or being helped. According to this theory, if assistance is not given those in need are forced to help themselves; the wage earner will not work if aid is given. However, families who come to want through the death or illness of the wage earner for the most part receive much more understanding and helpful treatment. In a few towns effort is made by the overseer to find employment for the men. This works fairly well in some instances.

In addition to the problems created by the attitudes toward relief, the case worker in an area lacking in social services may have many other problems to face: too heavy a case load; lack of resources such as group-work and recreation agencies; lack of funds for medical, dental, or optical care; absence of classrooms where children of limited ability can be given training adapted to their needs. The cases referred to her first are likely to be the result of chronic situations known to the overseers for generations. In cases where there is a problem of feeble-mindedness, chronic alcoholism,

or habitual prostitution, family reconstruction through case-work services may not be possible. In these cases it may be desirable to place the children in another environment to facilitate their future adjustment in society.

The responsibility for dealing with these problems rests not with the case worker alone but with all the citizens. What do they want to do about the situation? To arouse the people to meet the gaps in community resources the worker may interpret the needs through individual interviews. This is a time-consuming process and often accomplishes little. The understanding support of her program by some leader in the community can usually do more to win over a local official. Moreover, if the worker assumes the entire job of interpretation, no responsibility is placed on local citizens for supporting or furthering a social-work program.

The question, then, becomes one of helping the people to see that the welfare of all the children in the county is their problem, not just the job of the social worker. In this particular area the persons consulted, including the commissioner of public welfare and the State supervisor of child welfare, believed that what was needed was a group made up of representatives from each town in the county to act in an advisory capacity. The members of this group should be men and women who were representative of various groups and who were a "little ahead of their communities in their thinking on social welfare" and had the confidence of the people in the county. They must want to become acquainted with the social problems of the area and to cope with them, to help interpret the department's function to their fellow townsmen, and to talk with legislators to get through much needed social legislation and more adequate financial support.

How could we find these key people? Fortunately the State Children's Aid Society, the only private nonsectarian agency in the county, was well acquainted with the problems of the area and, through the assistance of the executive and one of her board members who lived in the area, suggestions for membership in this local advisory group were secured. With the Chil-

dren's Aid Society board member, and representatives of many other agencies, the commissioner and deputy commissioner were drawn into the planning and invitations to the first meeting were sent out by the commissioner. Anyone who was unable to participate was called upon to suggest others.

Letters and personal calls brought together the committee group representing the following: Two physicians active in town affairs, one shopkeeper, two priests (one chairman of a committee of the Catholic charities interested in delinquency), the secretary of the State Association of Overseers of the Poor, a banker, a principal of a school (chairman of the social service committee of the Catholic Daughters of America), a State's attorney, since become senator, a librarian now town representative in the legislature, two Protestant ministers (one, leader of a county ministers' group interested in social legislation), a public-health nurse, an old-age-assistance worker, five housewives who are active in farm bureau, home-demonstration clubs, grange, parent-teacher association, Children's Aid Society, and 4-H clubs.

This group has met monthly since its organization in October 1940. Some of the members live at a distance of 30 miles. After a period of getting acquainted and learning about the program of the department of public welfare and the settlement laws the group chose to study cases of delinquency. Members understood that all material was confidential. No names were used. The worker stressed at this point that material used would be considered as a committee problem rather than as an interesting bit of local news.

This study is arousing the members to the needs of the area as no speaker nor study made by a group from the outside could have done. The plan is to present to the group all the cases

of delinquent and predelinquent behavior referred to the child-welfare worker. A chart is made giving the name of the town, factors in the situation that may have contributed to the child's problem, and the treatment that is indicated and the action that is suggested by the committee. This may call for resources not now available to carry out the plans or to provide the preventive measures that will make more possible the normal development of other children in the community. The chart is filled in as each case is discussed. Later a summary is made which gives a fairly complete picture of the extent of the problem in the county as indicated by the number of referrals and of court petitions; the probable causes of the various problems; the prevention and treatment attempted; and a record of the committee's activity. From a period of doubt and fumbling as to its purpose the committee has come to realize that its advice on individual situations and community problems is valuable even though the members do not take direct action.

An interested group is now facing what is happening to some of our children and the probable causes of their difficulties. To change community conditions will be a long process but it will be based on careful study. The acceptance of responsibility for present conditions will be gradual but, meanwhile, a few children will benefit from the additional resources being made gradually available.

The local newspapers carry the story of each meeting and neighbors ask the members what this new committee is. A few cases have been referred by the group itself. The telephone still rings and many a letter arrives whose writer has no conception of the social worker's function. But the worker has now an assurance of the interest of the local people and their growing acceptance of responsibility.

Techniques of Community Interpretation and Organization¹

By HELEN G. ALCORN,

Wapello County Children's Worker, Ottumwa, Iowa

Newly created programs and an increasingly comprehensive network of social-welfare administration under Federal and State Governments have offered a challenge in rural areas that differs slightly from that in urban centers. Children's workers are faced with the problem of interpreting the services and organizing the community for social action. It is all rather new and bewildering to most of the midwestern States because they were without the ground work laid by private agencies in the more highly organized cities. With the addition of new services and agencies, our rural friends are likely to lump all public agencies together and refer to their representatives as "that welfare worker" or "that Government worker"—whether she be a child-welfare worker, a county nurse, or an old-age-assistance investigator. We, therefore, have a threefold function in community interpretation: (1) We must sell our services; (2) we must try to unravel some of the public's misconceptions of social work by the dissemination of information as changes occur within our organizations; and (3) we must attempt to organize communities so that the torches of our programs will be kept burning and light the way for our work in years to come.

I work in a county with a population of about 40,000. It is one of the largest counties in the State with child-welfare services and is called an area of special need. The county seat is the seventh largest city in the State but ranks third in industry and business. Our problems, therefore, are not entirely rural but include those of urban areas. Poor and crowded housing conditions, seasonal employment, "red-light" districts, and poorly regulated taverns all make their contributions to neglect, dependency, and juvenile delinquency.

In spite of the large number of juvenile cases in court, we have no special juvenile-court judge and seldom have private hearings. There are four judges in our district of seven counties, and each judge presides over juvenile matters arising within his jurisdiction.

Out in the county there is a serious lack of resources. Adequate relief, medical care, provision for recreation, care of feeble-minded persons, education for physically handicapped children, and vocational training are all grave problems. Some of these may be met locally, but they remain State-wide in scope. We must not excuse ourselves or give up on the basis of the things we do not have; that would be as bad as not taking a bath because we had no tub. It is for us who see these problems daily to deal with them at least in a limited way, not only on a case-work basis, but by making people aware of our needs in order to secure community action. We need a program to prevent minors from frequenting taverns and other breeding places of delinquency, to protect the rights of children in their own homes by the regulation of existing conditions which tend to cause the disintegration of family life. We must promote a positive attitude toward and preventive program for dependent and borderline families. This can be accomplished only through cooperative efforts of many.

In my county the need for a full-time children's worker was first interpreted to the board of supervisors by the district consultant for child-welfare services, who selected a few so-called "demonstration cases" to show what could be done through individualized social services to children. This created interest in the services and led to a request from the board for a full-time worker for the county. The consultant had convinced the men holding the purse strings that the county needed such a person.

¹ Paper given at the National Conference of Social Work, Section on Community Organization, Atlantic City, N. J., June 3, 1941.

Official boards and the public in general have something universally in common—that is, a desire to save money. When we can show by figures that we can save money and also increase the efficiency of service, we have used a most effective technique for community interpretation and organization. They must know our problems and what we are trying to do to meet them. Our county-welfare department has held meetings of boards and citizens to present our problems and discuss and propose remedies. We have invited county officials, including the sheriff, county attorney, city police, school authorities, physicians, and representatives of business, civic, and welfare organizations.

Getting set for action is one thing, but keeping the wheels in motion is another. Public opinion and “political complexions” of local administrations change so rapidly we must ever be alert both on our jobs and during our leisure time. Especially in rural communities must we be careful of what we do. We need not be chameleons. We have a right to our own ideas and their expression, but it is wise to exercise that right with a considerable degree of reserve. One soon becomes known not just as a so-called government worker, but as a personality identified with a particular job.

Many workers do not agree that use of our own leisure time has anything to do with our professional status. In the cities it may be possible to keep them separate, but out in the corn-and-hog States a publicly employed professional person's identity is not easily lost in his community, therefore, his own conduct and the extent of his participation and interest in civil life may become tools for his use in organizing the community for action. We need not be “joiners” and belong to every group to which we are invited, but a sincere interest and participation in community life is expected and respected.

A more tangible and widely used method of interpreting the program to the community is through the use of boards or advisory committees. Before a choice of members can be made the worker must know his community, the na-

ture of needs to be met, and the organization or agency problems involved. Some of us, even in rural districts, are fortunate enough to have a chamber of commerce, merchants' exchange, or some organized group which is active in gathering and compiling information regarding a community and hence offers valuable resources preliminary to social planning. Where such organizations are lacking the worker is obliged to seek his information bit by bit from the records in the county and from old settlers and other reliable citizens.

During my first week in the county as a children's worker, I obtained from such groups a complete picture of the community, which showed the number and types of industries, churches, schools, racial groups, civic organizations and their leaders, and so forth. In securing such information the worker meets many people and begins to lay a foundation for an advisory committee, such as exists in many counties in our State. They have helped raise funds for special projects, such as supervised playgrounds and recreation centers. They have aided in the formulation of policies and have been instrumental in stabilizing certain local conditions, sometimes administrative, which have tended to go out of balance. Such committees can be most effective in interpreting our work to the community, if they are carefully chosen and guided.

Rural social workers are faced with real problems in selecting those committees. Usually one wants to choose members representing various interests in the community; more particularly, one wants members with enthusiastic, intelligent, and open minds who will be cooperative and congenial, not only with the workers but also with each other. The latter is a real problem in some of our counties. There may be jealousies among individuals and among organizations which they represent. Such conditions may wreck the committee. Therefore the rural social worker must acquaint himself thoroughly with each prospective member for his advisory committee.

A consideration of community organization in our city would not be complete without mention of a newly created group called the Co-

ordinated Welfare Council. The idea for such a committee grew out of a need for better understanding of work done by various welfare organizations in the city. After three or four people had toyed with the idea, it was decided to have a meeting to consider a formal organization. We had three meetings with a steady increase in attendance because of the active interest shown by individuals in several agencies. Cooperation was a key word in the original plan, but in the third meeting there were grave symptoms that cooperation might collapse, because some people thought certain groups would have too much voting power by virtue of their large representation—yet the nature and purpose of the council made it doubtful that votes would be taken on any issue which would affect any of the organizations represented. The so-called “balance of power” was actually quite an unimportant matter.

In discussing needs in our rural areas I mentioned the need for education for the physically handicapped. Most of our counties have no provision for this group. When this matter was called to my attention by the mother of a crippled child, we made a survey of handicapped children through the school census, county nurse and doctor, welfare workers, and the newspaper. We had a number of responses and inquiries. Histories were taken,

and several children were examined by our psychologist for child-welfare services. The results of our survey were given to the board of education, which approved a plan for a special school since half the teacher's salary could be paid by State funds. For the past year we have had this school in a building centrally located in the city. It meets for 2 hours each morning. The result shown in the children's social behavior and training have convinced the board of education of the school's value, and the board plans to have a schedule for the entire day next year. The project has been a means of interpreting a need to the community and of supplying a service through the coordination of local and State resources of child welfare, public health, and education. It was possible to create a new resource from the scattered tools available.

The best method of community interpretation is the doing of one's work to the very best of his ability. The worker's attitude toward his job and community is just as important as the community's attitude toward the worker. In rural areas a worker is expected to practice what he preaches, for he can “interpret” 8 hours a day and get nowhere if he has not something concrete to show for his efforts. Actual case-work service to people, helping them to help themselves, may be the best approach to interpretation.

BOOK NOTES

MENTAL HYGIENE IN THE CLASSROOM. American Medical Association, 535 North Dearborn St., Chicago, 1940. 70 pp. 20 cents.

How would you help a child like this? is the subtitle of this pamphlet, which is the report of the joint committee on health problems in education of the National Education Association and the American Medical Association, with the cooperation of the National Committee for Mental Hygiene and the American Orthopsychiatric Association. There are 53 brief simply written sections dealing with behavior problems of children. Each topic begins with a case history gleaned from the classroom or playground with three suggestions as to treatment from which the reader is asked to choose. After some discussion of the mental-hygiene principles involved in the problem, the reader is told what should have been done for the best interest of the child as agreed upon by a group of mental-hygiene specialists. Brief generalizations are given at the end of each section summarizing the principle involved, which has great importance to anyone in association with children. A helpful bibliography is included. The pamphlet has value to teachers, social workers, parents and could be used effectively as a basis for further discussion.

M. M.

YOUR CHILD MEETS THE WORLD OUTSIDE, by Elizabeth F. Boettiger. D. Appleton-Century Co., New York, 1941. 179 pp. \$2.

It has long been recognized that the education of a child is far more than reading, writing, and arithmetic. Miss Boettiger points out that education is much more than all the facts the child learns in school; it is, in fact, the preparation of the child for the life he will lead as an adult. Education begins almost from the

time of birth and continues for many years. School—important though it is—is but one part of the child's education. Much of what he learns comes from the casual, often trivial, day-to-day contacts with family neighbors, friends, and, in fact, with everyone whose path crosses his.

As the child meets the world outside himself he is influenced and the pattern for his later attitude is being formed. Miss Boettiger divides the child's outside world into four parts each of which she discusses. She calls them the world of nature, the world of machinery, the world of people, and the community world. Under each topic Miss Boettiger discusses ways by which children are influenced and suggests means by which these influences can be directed in desirable channels. For example, the family in which the annoying habits of the neighbors are treated with understanding and consideration is one in which a child is more apt to develop an attitude of tolerance than one in which there are frequent outbreaks against the always-guilty other person. Miss Boettiger's book is full of practical suggestions accumulated during her many years as a teacher.

D. V. W.

SOCIAL WELFARE IN THE CATHOLIC CHURCH; ORGANIZATION AND PLANNING THROUGH DIOCESAN BUREAUS, by Marguerite T. Boylan. Columbia University Press, New York, 1941. 363 pp. \$3.

This is a history of the development of the diocesan charities movement in the United States with particular reference to the diocese of Brooklyn, N. Y., of which the author is executive secretary.

The appendix contains summaries of the work of diocesan bureaus of social welfare organized in 75 archdioceses and dioceses. This information was collected during the period 1937-39. There is also an 18-page list of selected references and a subject index.

The Children's Bureau *does not* distribute the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

GEORGE A. HALL

The recent death of George Albert Hall, general secretary of the New York State Child Labor Committee, is deeply regretted by all workers in the child-labor movement. Mr. Hall's death took place in Montclair, N. J., on October 5, 1941. He was 62 years of age.

Mr. Hall was one of the pioneer workers in the field of child labor. His service with the New York Child Labor Committee began in 1905, and was interrupted only by 4 years' (1921-25) leave of absence during which he was secretary of a commission appointed by the New York legislature to study the question of child-welfare legislation. Many important changes in the regulation of child labor in New York resulted from the work of this commission. The National Child Labor Committee, in an editorial in the *American Child* (November 1941) calls attention to his unremitting work for the elimination of the evils of child labor and pays tribute to his influence in bringing about the passage of the New York law in 1935, establishing a basic minimum age of 16 for employment of children.

Mr. Hall was long an active worker in the Boy Scout movement and was awarded the highest honor of the Boy Scout organization—the Silver Beaver, for "distinguished service to boyhood." He was a trustee of the Methodist Episcopal Church of Montclair and for some years served as superintendent of its Sunday school.

CONFERENCE CALENDAR

- | | | | |
|------------|--|--------------------|--|
| Dec. 27-29 | American Sociological Society. Annual meeting, New York. Secretary: Harold A. Phelps, University of Pittsburgh, Pittsburgh, Pa. | 1942
Feb. 17-20 | Council of Guidance and Personnel Associations, San Francisco. |
| Dec. 27-30 | American Economic Association, New York. Secretary: James W. Bell, Northwestern University, Evanston, Ill. | Feb. 18-20 | National Vocational Guidance Association. San Francisco. Information: N. V. G. A., 425 West One Hundred and Twenty-third Street, New York. |
| Dec. 27-30 | American Statistical Association. One hundred and third annual meeting, New York City. Secretary: R. L. Funkhouser, 1626 K Street NW., Washington. | Feb. 19-21 | American Orthopsychiatric Association. Nineteenth annual meeting, Detroit. Chairman of Publicity Committee: Helen P. Langner, M. D., Vassar College, Poughkeepsie, N. Y. |
| Dec. 28-30 | American Society for Public Administration. Second annual meeting, Chicago. Permanent headquarters: 1313 East Sixtieth Street, Chicago. | Feb. 21-26 | American Association of School Administrators. San Francisco. |
| Dec. 29-31 | National Conference on Family Relations. Fourth annual meeting, New York. Permanent headquarters: 1126 East Fifty-ninth Street, Chicago. | Apr. 6-10 | Second American Congress on Obstetrics and Gynecology, St. Louis, Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago. |
| 1942 | | Apr. 7-9 | Eighth annual conference on the Conservation of Marriage and Family Life, at the University of North Carolina and Duke University. Information: Professor Ernest R. Groves, University of North Carolina, Chapel Hill, N. C. |
| Jan. 24-26 | Child Labor Day. Information and materials from National Child Labor Committee, 419 Fourth Avenue, New York. | May 2-9 | Eighth Pan American Child Congress. Washington. |
| Feb. 4 | Sixth National Social Hygiene Day. Information and materials from American Social Hygiene Association, 1709 Broadway, New York. | | |

THE STORY OF MARY J.

A New Series of Five Posters

How community health services can safeguard the nutrition of the preschool child is the theme of the new poster series shown here in facsimile. The posters are in black and white and are 15 by 21 inches in size. Health workers and teachers can obtain these posters on request from the Children's Bureau.

THE STORY OF MARY J. NO. 1

HOW COMMUNITY HEALTH SERVICES SAFEGUARD THE NUTRITION OF THE PRESCHOOL CHILD

MARY J. HAS A HEALTH EXAMINATION

Mary, aged 4, is brought to the child-health conference by her mother. There is another child in the family—a boy aged 11. The father has died recently.



The doctor asks about M eating and examines M record form undernourished mors milk, ve well as more



The dentist finds Mary's He suggests eats.

THE STORY OF MARY J. NO. 2

HOW COMMUNITY HEALTH SERVICES SAFEGUARD THE NUTRITION OF THE PRESCHOOL CHILD

THE NUTRITIONIST

Learns from Mrs. J... how Mary spends her day

She tells Mrs. J... how to improve Mary's diet and her eating and sleeping habits

HOW MARY SPENT A TYPICAL DAY

8:45 a. m. Get up

7:00 a. m. Breakfast

A GOOD DAYS PROGRAM FOR A 4-YEAR-OLD GIRL

7:00 a. m. Get up

7:30 a. m. Eat breakfast

THE STORY OF MARY J. NO. 3

HOW COMMUNITY HEALTH SERVICES SAFEGUARD THE NUTRITION OF THE PRESCHOOL CHILD

THE NUTRITIONIST

asks Mrs. J... to keep a record for a week of how she spends money for food



HOW MARY J. COULD GET MORE VALUE FOR HER DOLLARS

Milk	
1 quart	\$1.27
Vegetables and fruit	
Cabbage 10 pounds	2.00
Beets 10 pounds	
Carrots 10 pounds	
Onions 10 pounds	
Garlic 1 pound	
Peas 10 pounds	
Beans 10 pounds	
Whole wheat flour 8 pounds	
White flour 8 pounds	
Corn meal 1 pound	
Butter 1 pound	
Eggs 1 dozen	
Apples 10 pounds	
Oranges 10 pounds	
Strawberries 10 pounds	
Blackberries 10 pounds	
Blueberries 10 pounds	
Apples 10 pounds	
Oranges 10 pounds	
Strawberries 10 pounds	
Blackberries 10 pounds	
Blueberries 10 pounds	
Apples 10 pounds	
Oranges 10 pounds	
Strawberries 10 pounds	
Blackberries 10 pounds	
Blueberries 10 pounds	

HEALTH AND WELFARE WORKERS CONFER

The nurse and the nutritionist find that Mrs. J... is not buying the food that Mary needs, although she is spending enough money for food. She can use more money for milk if she buys bread and cereals more wisely. She can make her fruit and vegetable money go much further by buying for food value rather than for ease of preparation. After buying food she has too little money left for other needs.



The social worker is consulted and says that Mrs. J... may be eligible for aid to dependent children.



The nurse visits the family. She shows Mrs. J... how to make what she has go as far as possible. She suggests to Mrs. J... that she apply for aid to dependent children.

THE STORY OF MARY J. NO. 5

HOW COMMUNITY HEALTH SERVICES SAFEGUARD THE NUTRITION OF THE PRESCHOOL CHILD

THE FAMILY LEARNS HOW TO HELP ITSELF



The older boy, with help from a county agricultural agent, plants a vegetable garden.



The mother joins a cooking class, where she learns to make whole-wheat bread, to prepare low-cost foods, and to can the vegetables from her garden.



Mary goes to a nursery school that has just been opened in the community and learns good habits of eating, resting, and playing out of doors in the sun.

UNITED STATES DEPARTMENT OF LABOR-CHILDREN'S BUREAU

UNITED STATES DEPARTMENT OF LABOR-CHILDREN'S BUREAU

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at \$1 a year; foreign postage, \$0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

Social Statistics

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C O N T E N T S

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GROUP ACTIVITIES OF LOCAL PRIVATE AGENCIES IN THE LEISURE-TIME

FIELD, 1940-41 - - - - - 3

CLINIC SERVICE IN URBAN AREAS, 1940 - - - - - 12

The SOCIAL-STATISTICS SUPPLEMENT is issued by the Children's Bureau four times a year, in connection with the Bureau's monthly publication, THE CHILD.

The purpose of the supplement is to make available for general use summaries of current social statistics related to child welfare, prepared by the Bureau's Division of Statistical Research. While material presented in the supplement will be based largely on reports forwarded by health and social agencies in connection with the Bureau's project for the registration of social statistics, closely related material from other sources will also appear from time to time.

GROUP ACTIVITIES OF LOCAL PRIVATE AGENCIES IN THE LEISURE-TIME FIELD, 1940-41

The defense emergency has directed attention to many needs, and on the home front not the least of these has been a renewed interest in noncommercial leisure-time activities required by a population living through increasingly strenuous times.

The statistics available on leisure-time activities, particularly current statistics, are limited. A primary problem is that the field is wide and difficult to define. It includes a wide range of activities, of which many are not directly associated with any established institution or agency. Of the established agencies, a division commonly is made between those under public and those under private auspices. The private agencies, because of their generally smaller size, their frequent association with national organizations and local community chests and councils of social agencies, and their emphasis on group activities where fairly detailed records are required for proper administration of the program, have generally been in a better position to provide statistical reports of their activities.

The Agencies Reporting.

The present article deals with reports on group activities submitted by some of these private agencies. Agencies in the private leisure-time field have been reporting through the Children's Bureau social-statistics project to local councils of social agencies and the Bureau for the past few years.

The number and types of local private agencies reporting to the Children's Bureau in 1941

and discussed in the present article are shown in table 1, together with the number of urban areas represented. By 1941, 5 years after the introduction of trial reporting forms, the reporting had expanded to the point where 30 of the 45 areas participating in the project had maintained substantially complete coverage of this group of agencies over a period of 18 months. These 30 areas had a total population in 1940 of 14,900,000. They included 32 percent of the population in all cities of 100,000 or more in the United States.

Table 1.--Number and types of local private agencies supervising group activities and reporting to the Children's Bureau, June 1941

Types of organization	Number of agencies	Urban areas represented
Total.....	308	30
Settlements and centers.....	194	28
Y.M.C.A.....	31	28
Y.W.C.A.....	33	29
Boys' clubs.....	14	11
Other.....	36	22

The group of private agencies not included in the present article consists of the national program groups--the Boy Scouts, the Girl Scouts, and the Camp Fire Girls. Statistics reported by these boys' and girls' programs will be treated separately at a later date. 1/ Boys and girls of this age, however, are also very active in the

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1/ Earlier reviews of statistics reported by agencies in the leisure-time field were given in Social Statistics, December 1937 and December 1938. Statistics on local private agencies and national program groups were considered separately.

local private agencies discussed here, incomplete membership figures reported indicating that 51 per cent of their members are under 18 years of age.

Although, because of basic differences in record systems, it is not possible to combine the reports of all private and public agencies, some rough indication of the relative size of these various divisions of the field can be given. Public agencies are, of course, by far the largest. The incomplete annual reports now submitted by a partial list of these public agencies to the National

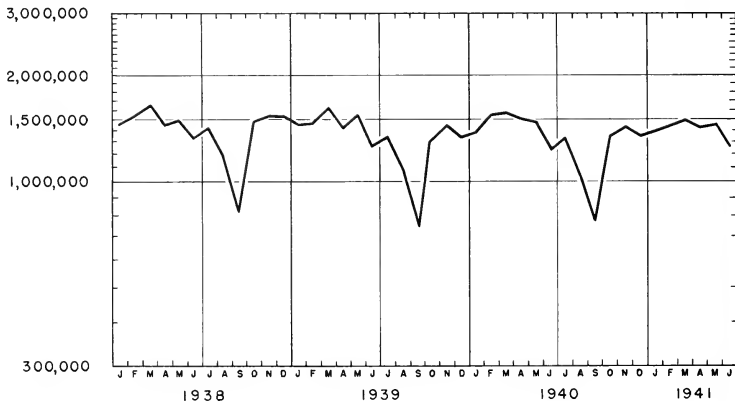
ance, but the national-program groups of the Boy Scouts and Girl Scouts and the Camp Fire Girls have established detailed reports on membership. The figures for these groups in the areas covered in the present article indicate that they had a membership during 1940 equal to about two-fifths of that of the group of private agencies being considered here.

Attendance Since January 1938.

Although fairly complete reporting for 30 areas was not obtained until 1940, 199 agencies

FIG. 1.-ATTENDANCE AT GROUP ACTIVITIES REPORTED BY 199 LOCAL AGENCIES,
JANUARY 1938-JUNE 1941

Number of persons



Recreation Council, ^{2/} show an attendance in these areas during 1940 of more than $2\frac{1}{2}$ times the attendance reported by the private agencies represented in this article. Reports of public agencies are as yet generally limited to an estimate of attendance.

^{2/} Recreation, Bulletin of the National Recreation Association, New York, June 1941.

have submitted sufficiently complete reports since January 1938 to give some indication of the movement in attendance ^{3/} at group activities over the

^{3/} These attendance figures represent aggregates and not different persons. Thus an attendance count is made each time a person attends a group activity, regardless of how often this may occur during the month.

3½-year period ended June 30, 1941. The total for 1940 was about 5 percent below the level of 1938. A distinct seasonal movement is noted in the monthly figures. The high point for each year comes in March followed by a decline during the summer. Not reflected in these figures or others presented in the present article, however, are the activities of camps, which for many of these agencies make up an important summer activity. The low point is in September when, for many of these agencies, a program-year ends and a new year begins (fig. 1).

Attendance by Type of Group,

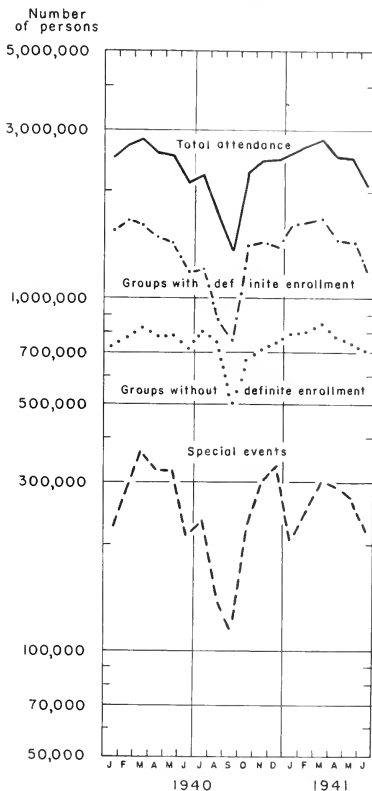
January 1940-June 1941.

In table 2 and figure 2 the attendance data for all the 308 agencies reporting during the per-

Table 2.--Attendance at group activities by type of group and by month, in 30 urban areas, January 1940-June 1941

Month	Total attendance	Percent of total		
		Groups with definite enrollment	Groups without definite enrollment	Special events
1940				
January...	2,517,000	62	29	9
February...	2,713,000	61	28	11
March.....	2,832,000	58	29	13
April.....	2,593,000	57	30	13
May.....	2,544,000	57	31	12
June.....	2,132,000	56	34	10
July.....	2,247,000	54	36	10
August....	1,771,000	50	42	8
September..	1,377,000	55	37	8
October...	2,297,000	61	29	10
November..	2,474,000	59	29	12
December..	2,486,000	57	30	13
1941				
January...	2,609,000	62	30	8
February...	2,719,000	61	29	10
March.....	2,846,000	60	30	10
April.....	2,539,000	58	31	11
May.....	2,510,000	59	30	11
June.....	2,129,000	57	33	10

FIG. 2.-ATTENDANCE AT GROUP ACTIVITIES BY TYPE OF GROUP; 308 LOCAL AGENCIES JANUARY 1940 - JUNE 1941



iod January 1940-June 1941 are divided to show the attendance by the three types of group activity commonly recognized in this field. The greatest part of the attendance in all months was shown by

groups with definite enrollment. These are groups in which the same individuals are expected to be present at each session and include clubs, classes, and teams. This type of group organization is particularly emphasized by private agencies in the leisure-time field.

Attendance at groups without definite enrollment showed the least fluctuation during the 18-month period. These groups include game rooms, forums, dances, playgrounds, and other activities at which a leader is scheduled to be present but at which no definite group is expected to attend. The relatively greater importance during the summer time of groups without definite enrollment reflects, at least in part, the importance of supervised playgrounds and play rooms during that period. Thus from June to September 1940 and in June 1941 attendance at this type of group made up from 33 to 42 percent of the attendance at group activities reported by these agencies, whereas in other months the percentage varied between 28 and 31. Attendance at special events, which are group activities not regularly scheduled or held less frequently than once a month and which include all activities open to the total agency membership and the general public, varied in importance from 8 to 13 percent of the attendance at all group activities. The attendance at this type of group showed the greatest relative fluctuation.

Number of Groups and Sessions.

Attendance figures have been the most frequently used statistics in the leisure-time field because they are in terms of a common denominator

which can be used in connection with various types of organized activities. However, for group activities alone it is possible to make use of statistics in terms of number of groups and sessions. In table 3 such statistics are shown separately for groups with and without definite enrollment for the 18-month period January 1940-June 1941. Figures have been computed for the average attendance per session as well as for the average number of sessions per group during each month. The relationship between the number of groups and number of sessions is fairly constant from month to month, there being on the average 4 sessions a month for groups with definite enrollment and approximately 5 sessions or periods per month for groups without definite enrollment. The figures for groups with definite enrollment mean that each enrolled person was expected on the average of 4 times a month. Figures for groups without definite enrollment simply indicate that the average group was scheduled 5 times a month, some undoubtedly being scheduled much more frequently, but they do not indicate that the same persons were in attendance at each session.

The number of groups with definite enrollment and the number of sessions of such groups varied considerably during the period, and while they followed in general the seasonal changes in attendance there were significant differences, as shown in figures on the average attendance per session. Thus, while the attendance dropped during the summer months, the number of sessions dropped by a proportionately greater amount. As a result the average attendance per session in the

Table 3.--Attendance, number of regularly scheduled groups, and number of sessions reported by 308 local agencies, January 1940-June 1941

Month	Groups with definite enrollment					Groups without definite enrollment				
	Attendance	Number of groups	Number of sessions	Average attendance per session	Average number of sessions per group	Attendance	Number of groups	Number of sessions	Average attendance per session	Average number of sessions per group
1940										
January...	1,564,376	25,182	102,862	15	4.1	723,750	4,945	23,813	30	4.8
February...	1,662,913	26,204	105,359	16	4.0	768,722	5,149	24,484	31	4.8
March.....	1,633,467	26,524	102,583	16	3.9	828,765	5,404	25,411	33	4.7
April.....	1,491,109	23,966	95,989	16	4.0	775,230	5,314	25,043	31	4.7
May.....	1,442,401	21,914	87,375	17	4.0	780,994	5,327	24,388	32	4.6
June.....	1,198,663	15,574	59,088	20	3.8	721,353	4,663	21,239	34	4.6
July.....	1,205,691	11,660	58,074	21	5.0	805,549	4,489	22,682	36	5.1
August....	876,580	9,434	41,914	21	4.4	748,712	4,266	20,952	36	4.9
September.	758,290	13,140	45,358	17	3.5	503,286	3,568	16,099	31	4.5
October...	1,410,403	21,059	86,303	16	4.1	669,469	4,818	21,719	31	4.5
November..	1,458,438	23,802	92,498	16	3.9	718,368	5,216	22,950	31	4.4
December..	1,408,069	24,275	87,247	16	3.6	748,251	6,048	22,918	33	3.8
1941										
January...	1,611,200	25,516	101,917	16	4.0	788,050	6,091	26,081	30	4.3
February...	1,665,480	26,283	103,058	16	3.9	793,907	5,193	24,058	33	4.6
March.....	1,696,635	26,618	105,791	16	4.0	848,519	5,432	25,864	33	4.8
April.....	1,468,647	24,819	94,106	16	3.8	777,847	5,121	24,686	32	4.8
May.....	1,490,010	21,840	82,602	18	3.8	745,979	4,898	24,936	30	5.1
June.....	1,208,270	15,229	58,384	21	3.8	701,275	4,510	22,969	31	5.1

summer months was 20 or 21 compared with about 16 in other months. The reassembling of groups and the establishment of new groups in September is reflected in these figures, but enough of the groups were evidently formed late in the month to prevent a comparable increase in the number of sessions.

During the winter months the ratio of the number of groups with definite enrollment to the number without definite enrollment was about 5 to 1, but during the summer months this ratio fell to approximately 3 to 1. The average attendance per session at groups without definite enrollment during most months was approximately twice that of the groups with definite enrollment.

Attendance and Group Statistics by Type of Agency.

The figures for the month of March 1941, the month with greatest attendance in the series, have been analyzed by type of agency (table 4). The 194 settlements and centers accounted for a little more than a third of the total attendance, the 31 Y.M.C.A.'s for slightly less than a third. The Y.W.C.A.'s reported four-fifths of their total attendance accounted for by regularly scheduled groups with definite enrollment. Boys' clubs reported a little more than one-third, and the three other types of agencies approximately three-fifths, of their attendance at this kind of group.

In average attendance per session and average number of sessions per group there appeared to be

Table 4.—Summary of group activities of private agencies in 30 urban areas, March 1941

Type of agency or urban area	Number of agencies	Total attendance	Groups with definite enrollment				Groups without definite enrollment				Special events at-tendance	
			Attendance	Number of groups	Number of sessions	Average at-tendance per session	At-tendance	Number of groups	Number of sessions	Average at-tendance per session		
Total.....	308	2,845,840	1,696,635	26,618	105,791	16	848,519	5,432	25,864	33	4.8	300,686
Settlements and centers.....												
Y.M.C.A.....	194	1,168,232	666,576	10,253	43,562	15	385,503	2,426	12,956	30	5.3	116,153
Y.W.C.A.....	31	935,495	583,665	8,232	36,563	16	225,485	1,590	7,096	32	4.5	126,145
Y.N.C.A.....	33	314,987	294,676	5,666	16,015	16	32,466	545	1,355	29	2.4	25,845
Boys' clubs.....	14	249,471	87,880	731	4,344	20	146,628	350	2,824	52	8.1	14,963
Other.....	36	177,655	107,638	1,033	5,307	20	52,437	521	1,663	32	3.2	17,580
Total.....	308	2,845,840	1,696,635	26,618	105,791	16	848,519	5,432	25,864	33	4.8	300,686
Total.....												
Akron.....	4	76,042	60,315	1,000	3,221	19	10,607	166	745	14	4.5	5,120
Baltimore.....	12	77,639	50,534	802	3,087	16	15,290	229	394	43	1.5	11,815
Birmingham.....	10	90,247	57,022	582	3,044	19	25,730	109	799	32	7.1	7,495
Cincinnati.....	12	170,450	107,699	1,375	5,696	19	37,180	357	997	37	2.8	25,571
Cleveland.....	20	274,622	142,515	2,748	10,462	14	100,589	636	3,312	30	5.2	34,518
Columbus.....	11	153,592	70,442	1,344	5,010	14	45,087	428	1,532	29	3.6	8,063
Dallas.....	4	29,008	11,985	163	777	15	14,125	76	505	28	6.6	2,898
Denver.....	15	92,965	54,481	679	2,598	21	34,396	213	910	38	4.3	4,088
Des Moines.....	7	82,567	44,522	561	2,362	19	34,150	64	795	43	12.4	3,895
Detroit.....	22	203,905	128,712	1,669	7,744	17	43,510	193	801	54	4.2	31,683
Duluth.....	2	21,951	16,166	245	895	18	4,177	56	233	18	4.2	1,408
Hartford.....	5	45,019	38,142	661	2,505	11	12,749	82	514	25	6.3	4,128
Houston.....	6	60,553	39,483	659	2,447	16	12,466	133	483	26	3.6	8,604
Indianapolis.....	13	135,316	71,600	964	4,868	15	43,475	210	1,001	48	4.8	13,281
Kansas City, Mo.....	13	89,719	51,525	645	3,537	15	33,543	138	1,285	26	9.3	4,651
Louisville.....	9	41,656	27,618	568	1,988	14	10,996	73	345	32	4.7	3,042
Milwaukee.....	9	61,249	41,638	646	2,676	16	12,653	127	436	29	3.4	6,958
Minneapolis.....	18	142,747	96,902	1,905	6,088	16	31,473	265	1,155	27	4.4	20,372
New Haven.....	8	63,441	49,550	901	3,066	16	6,911	59	139	50	2.4	6,980
New Orleans.....	11	37,123	21,137	358	1,456	15	10,297	100	299	34	3.0	5,889
Omaha.....	7	33,328	30,340	516	1,844	15	40,994	201	1,789	23	8.9	2,034
Providence.....	8	66,186	32,437	593	2,285	14	27,367	84	403	68	4.8	6,382
Richmond.....	11	83,374	51,323	637	2,596	21	23,671	149	1,076	22	7.2	6,380
St. Louis.....	14	194,559	124,621	1,943	8,292	16	44,369	406	1,368	32	3.4	17,569
St. Paul.....	10	69,293	47,958	939	3,366	14	10,545	114	282	37	2.5	10,790
San Francisco.....	16	137,817	74,158	1,052	4,437	17	52,481	291	1,465	36	5.0	11,178
Sioux City.....	6	32,551	24,101	372	1,159	21	5,447	73	255	21	3.5	3,033
Syracuse.....	7	77,279	52,981	820	3,327	16	13,052	143	405	32	2.8	11,246
Washington, D. C.....	16	152,428	59,046	989	4,118	14	83,031	230	1,958	42	8.5	10,351
Wichita.....	3	33,214	15,482	282	850	18	3,268	27	223	15	8.3	14,464

a significant difference between the figures for boys' clubs and those for the Y.M.C.A., Y.W.C.A., and settlements. A similar variation appeared in the case of regularly scheduled groups without definite enrollment, where the average size of the group and the frequency of meetings were greater in the case of boys' clubs than in the case of the other agencies.

Attendance and Group Statistics by Area.

Each of the areas now reporting on group activities of private leisure-time agencies has indicated that its reports cover substantially all of such activity carried on locally. Nevertheless, because of the difficulties inherent in defining this field, the statistics for the individual areas should be considered only a rough indication of the relative size of the programs. With this limitation recognized, the figures by area are tabulated for March 1941 in table 4. The total attendance reported during the month varied from 275,000 in Cleveland to 22,000 in Duluth.

A summary of the attendance figures by type of group for the month showed the proportion accounted for by groups with definite enrollment varying from 79 percent in Akron to 39 percent in Washington. Groups of this type showed an average attendance per session during March varying from 14 to 21. The average number of sessions per month varied from 3.0 to 5.5.

The proportion of the monthly attendance accounted for by regularly scheduled groups without definite enrollment varied from 10 percent in Wichita to 49 percent in Dallas, and the average

attendance at a session of such groups varied from 14 in Akron to 68 in Providence. The number of sessions per group of this type varied from 1.5 to 12.4. None of the areas reported more than 16 percent of their attendance at special events, except Wichita, where 44 percent was reported. Unusually large activities during the month in Wichita accounted for this percentage; during the entire year special events in that area accounted for only 20 percent of the total attendance.

Membership.

Since in attendance statistics a count is made of each person each time he attends a group activity, these statistics do not indicate how many persons are being served nor how frequently each person is taking part in the agency program.

In the case of regularly scheduled groups with definite enrollment, records can and are maintained by each individual group to provide this information. Such enrollment data, however, have been reported centrally only on a duplicated basis--that is, a total of enrollment in all groups counting each enrollment regardless of the fact that the same person may be enrolled in more than one group. Perhaps more important is the fact that these enrollment figures are based generally on rules adopted by the individual group. Thus, enrollment may be based on interest, attendance, the payment of a small fee, or other criteria. Some areas have attempted to develop a means of making the enrollment figures for all groups comparable by adopting a standard rule for entering a person's name and for removing it from the roster, but in general the figures remain primarily of use

to the individual group and not directly comparable among groups.

For groups without definite enrollment, such figures are by the very organization of the group not obtained.

There remains, however, the important over-all membership count for the agency as a whole for which some figures have been made available. In the first place, these figures are cumulative for a year, since many agencies have not found it practicable to develop a satisfactory means of dropping inactive members during the year. In the sec-

ond place, although an attempt has been made to limit these figures to persons taking part in group activities, they may include in some agencies a few members who have made only individual use of the agency's facilities. In spite of these limitations the total cumulative membership figures are believed to be of considerable assistance in interpreting the statistics of group activities.

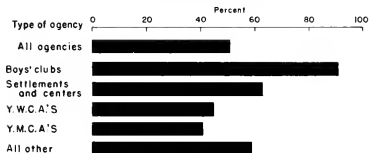
Twenty-eight of the 30 urban areas reported cumulative membership figures for the year 1940. As is shown in table 5 the figure for the combined 28 areas amounted to 773,000 or approximately

Table 5.--Cumulative membership and total attendance at group activities in private agencies in 28 urban areas, 1940

Urban area	Number of agencies reporting	Cumulative membership reported for 1940				Attendance at organized group activities during 1940	Ratio of attendance at organized groups to cumulative membership
		Members	Percent of total population	Members under 18 years of age			
				Members	Percent of total members		
Total, 28 areas.	294	778,097	5.4	393,771	51	23,745,159	31
Akron.....	4	30,477	9.0	15,256	50	626,459	21
Baltimore.....	12	25,538	3.0	9,882	39	677,721	27
Birmingham.....	10	18,887	4.1	10,614	56	1,059,370	56
Cincinnati.....	12	71,390	11.5	34,050	48	1,213,127	17
Cleveland.....	20	101,730	8.4	45,254	44	2,462,282	24
Columbus.....	11	28,210	7.3	19,554	69	1,120,933	40
Dallas.....	4	7,487	1.9	4,168	56	253,804	34
Denver.....	15	23,535	7.3	14,352	61	1,030,023	44
Detroit.....	22	39,689	2.0	22,396	56	1,460,402	37
Duluth.....	2	8,299	8.2	3,701	45	146,616	18
Hartford.....	5	12,719	5.1	4,935	39	377,616	30
Houston.....	6	32,079	6.1	22,618	71	725,977	23
Indianapolis.....	13	30,654	6.7	14,679	48	943,906	31
Kansas City, Mo.....	13	11,835	2.5	9,446	80	882,008	75
Louisville.....	8	17,666	4.6	7,221	41	447,072	25
Milwaukee.....	9	22,064	2.9	13,725	62	437,481	20
Minneapolis.....	18	58,067	11.7	31,081	54	1,162,075	20
New Haven.....	8	19,215	8.6	7,362	38	545,659	28
New Orleans.....	11	12,095	2.4	6,962	58	356,443	29
Omaha.....	7	14,198	5.7	7,014	49	614,901	43
Providence.....	8	19,456	7.7	10,511	54	626,443	32
Richmond.....	11	22,777	8.6	10,396	46	842,586	37
St. Louis.....	14	40,734	3.7	18,493	45	1,931,492	47
St. Paul.....	10	19,839	6.4	10,246	52	537,175	27
San Francisco.....	16	52,259	8.2	15,027	29	1,314,899	25
Sioux City.....	6	7,615	7.3	4,285	56	232,594	31
Washington.....	16	24,064	3.6	17,838	74	1,449,240	60
Wichita.....	3	5,539	3.9	2,705	49	266,855	48

5.4 persons per 100 population in these areas. An analysis of these figures indicates that slightly more than half of the members were under 18 years of age. In figure 3 the proportion of members who were under 18 is shown for each of the various types of agencies, and ranges from 91 percent for the boys' clubs to 41 percent for the Y.M.C.A.'s in these 28 areas.

FIG.3.-PERCENTAGE OF CUMULATIVE MEMBERSHIP UNDER 18 YEARS OF AGE, 28 URBAN AREAS, 1940



A comparison of the attendance and membership figures will give some indication of how active the membership is. In this comparison attendance at special events which include activities open to the general public is excluded, and only the attendance at regularly scheduled group meetings is used. The annual attendance at such activities is seen to be 31 times as great as the membership. It is important to bear in mind that the membership figures used are cumulative. They include all persons registered at any time during the year. The average membership during the year if available would be considerably lower and would increase the ratio of attendance to membership.

The 1940 membership figures for the 28 individual urban areas are also shown in table 5. Although variations among areas must be interpreted with special care in this field, where record keeping is relatively undeveloped, the differences

appear to be too great to be attributable entirely to such factors. The number of members per 100 population varied from 11.7 in Minneapolis and 11.5 in Cincinnati to 1.9 in Dallas and 2.0 in Detroit. Fifteen of the areas reported 50 percent or more of the members to be under 18 years of age. At one extreme was San Francisco with 29 percent of its members under 18 and at the other, Kansas City with 80 percent. Membership figures for the individual areas, considered in relation to attendance at regularly scheduled group activities during 1940, also showed wide variations. The extremes were reported by Cincinnati and Kansas City where the attendance figures were 17 and 75 times their respective membership figures.

The record system that is emerging in many of these agencies as a result of this community-wide reporting project is believed to give these agencies a better understanding of their own program in relation to that of other private agencies, and to an extent, to those of all agencies engaged in leisure-time activities. The agencies participating in this reporting plan frequently carry on many other important activities in addition to these group activities and those, of course, are not reflected in the statistics. The group activities of the various agencies are, however, quite comparable, and it is the hope and intent of this reporting project to provide a means of keeping a record of this important activity. The reporting system has been slow in developing, but experience to date would seem to indicate that it is proving successful and is furnishing a fair report of the group activities conducted by the various agencies.

CLINIC SERVICE IN URBAN AREAS, 1940

Among large urban areas throughout the United States, clinics operated by public and private agencies have an important place in community programs for providing medical service to the needy and for maintaining public-health control. Although individual areas differ greatly in the extent to which this type of service is used, in a recent study of expenditures in a number of urban areas during 1940, it was found that, on the whole, expenditures for clinic service were greater than for any other type of health service except hospital in-patient service. 1/

The present article summarizes certain statistical data in terms of visits and expenditures reported by clinics in a group of large urban areas. The clinics reported provide free and low-cost service that is locally considered to be a part of the welfare program in their respective communities. Their reports were submitted to the Children's Bureau through its project for the registration of social statistics. 2/

As defined for purposes of reporting in this project the field of clinic service includes only clinics and medical conferences that are under the charge of a physician or a dentist and are expected to be held regularly at the same time and place. 3/

1/ The Community Welfare Picture in 34 Urban Areas, 1940, pp. 41 and 42. Children's Bureau, Washington, June 1941.

2/ A report on clinic service in urban areas during January-June 1939 was included in Social Statistics, December 1939.

3/ Separately organized mental-hygiene clinics and clinics and medical conferences that are provided as part of specially organized programs of school-health service are not included here but

Agencies reporting in this field include hospital out-patient departments, dispensaries, public-health departments, and other agencies that operate medical and dental clinics for the diagnosis and treatment of disease and for the supervision of well individuals. Although many of the agencies operate general medical and surgical clinics, a large part of their service is provided in specialized clinics, particularly in venereal-disease, tuberculosis, heart-disease, dental, and eye, ear, nose, and throat clinics, and in clinics and medical conferences for maternity care, pediatrics, and child health.

Number of Clinic Visits, 1936-40.

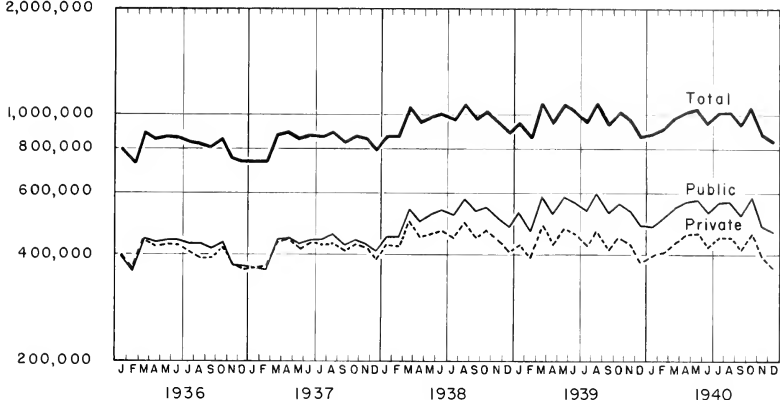
Although reporting has been much more complete in 1940, when 443 agencies in 38 areas submitted monthly reports, 272 agencies have submitted monthly reports since January 1936. The number of visits 4/ reported monthly by these agencies during the period January 1936 through December 1940 are charted in figure 1 with visits to public and to

are covered in other fields of the social-statistics project. Clinics organized for profit; those operated exclusively for the care of the residents of a maternity home, children's institution, or home for the aged; and those that are operated by an industrial or commercial establishment and that provide care only for the employees of the establishment are excluded from the reporting project.

4/ A clinic visit as defined for reporting in the social-statistics project is the occasion when treatment or any other personal professional service is given to a patient. Agencies reporting in the project are instructed to count only one visit to any one clinic for a given attendance at the agency even though several different types of treatment were provided. When a service is given in more than one clinic or medical conference during a single attendance at the agency, a visit is to be counted for each of these clinics and medical conferences.

FIG. 1—CLINIC VISITS, JANUARY 1936–DECEMBER 1940, AS REPORTED BY 66 PUBLIC AGENCIES AND 206 PRIVATE AGENCIES

Number of
clinic visits
2,000,000



private agencies shown separately. As to the proportion of total visits reported by public and by private clinics, the distribution in this series compares closely with that for the larger group of 443 agencies reporting during 1940, which represent practically all of the service provided in 38 urban areas.

The average monthly number of clinic visits during 1940 was 17 percent above the average for 1936 and only slightly below that in the year 1939 when the highest figure was reached. The increase over the 5-year period took place almost entirely in 1938 when the number of visits to both public and private clinics rose markedly, averaging 15 percent over the number in the preceding year.

The average monthly number of visits to public clinics in 1940 showed an increase of 28 percent

over the 1936 average. In private clinics, where the number of visits declined during the last 2 years of the period, the number during 1940 was only 6 percent above that of 1936.

The operation of clinics on certain days of the week only and the consequent differences in the number of sessions from month to month is reflected in the sharpness of the monthly changes in the number of visits. This is substantiated by the comparable fluctuations in the number of visits to public and to private clinics. With few exceptions an increase or decrease in the number of visits reported by clinics under public auspices was accompanied by a similar change in the number reported by clinics under private auspices.

A comparison of the figures by months for each year fails to indicate any clear seasonal movement.

On the average, however, the smallest number of visits were made during December, January, and February and the greatest number during March and August.

Clinic Service in 38 Urban Areas, 1940.

As stated above, the reporting in the clinic field during 1940 represents considerably higher coverage of total clinic service in urban areas than has been available through the social-statistics project up to the present time. 5/ Data are reported here on 38 urban areas having a population of 25,100,000 or 19 percent of the total population of the United States in 1940 and including 50 percent of the total population in cities of 100,000 or more population. The services of 443 agencies, 122 under public auspices and 321 under private auspices, are included. In certain areas a few agencies did not submit reports. 6/ Information forwarded to the Children's Bureau from these areas, however, indicates that for the 38 areas combined the services that were omitted probably do not include more than 1 percent of the visits made to public clinics and 3 percent of those to private clinics of the types included here.

5/ The increase in coverage during 1940 occurred under a new plan whereby the Children's Bureau issues a monthly trend series based on reports from urban areas providing reasonably complete information on the total services of their public and private agencies and supplying reports on identical agencies each month. A discussion of this plan was given in Social Statistics for March 1940.

6/ Data covering more than 5 percent of the public or private services were reported to be lacking in the following cases: public agencies not reporting in Kansas City (Mo.), Minneapolis, and San Francisco; private agencies not reporting in Cincinnati, Duluth, Kansas City (Mo.), Providence, San Francisco, Washington (D.C.), and Wilkes-Barre.

During 1940 approximately 17,000,000 visits were made to clinics in these 38 urban areas. More than half (57 percent) were made to clinics under public auspices.

Of the various types of agencies reporting in the clinic field the out-patient departments of public hospitals reported the greatest number of visits, nearly equalled by similar departments of private hospitals (table 1). Public and private agencies of this type together provided 60 percent of the total clinic service in the 38 areas. Visits to clinics operated by city, county, and State health departments, for the most part visits to venereal-disease clinics and to maternal and child-health clinics and medical conferences amounted to 22 percent of the total.

Table 1.—Percentage distribution of clinic visits by type of agency; 38 urban areas, 1940

Type of agency	Number of agencies	Visits	
		Number	Percent
All types.....	443	16,957,226	100
Public hospitals.....	48	5,218,713	31
Private hospitals.....	166	4,878,033	29
Public-health departments..	55	3,834,260	22
Private health agencies....	155	2,364,757	14
Public-welfare departments.	11	537,682	3
Other public agencies.....	8	123,781	1

The number of visits reported by individual areas during 1940 are shown in table 2, together with the proportion of the total visits accounted for by public and by private agencies. The total number of visits reported varied from 14,700 in Canton to more than 3,100,000 in Chicago. Because it is not possible to exclude from these current figures the number of visits in many areas made by

Table 2.-Visits to clinics and medical conferences; 38 urban areas, 1940

Urban areas (grouped according to population in 1940)	Number of agencies	Visits		
		Total	Percent of total	
			Under public auspices	Under private auspices
Total.....	443	16,957,226	57	43
More than 500,000 population:				
Baltimore.....	26	955,494	39	61
Buffalo.....	23	434,259	55	45
Chicago.....	40	3,100,658	64	46
Cincinnati.....	11	361,504	57	33
Cleveland.....	15	668,281	30	70
Detroit.....	23	1,166,806	50	50
Houston.....	12	368,320	77	23
Los Angeles.....	25	1,557,631	69	31
Milwaukee.....	12	507,078	80	20
Pittsburgh.....	31	627,528	11	89
St. Louis.....	16	1,023,395	55	45
San Francisco.....	16	720,804	48	52
Washington, D. C.....	13	673,031	56	44
250,000--500,000 population:				
Akron.....	5	90,626	49	51
Atlanta.....	13	521,854	91	9
Birmingham.....	7	207,645	90	10
Columbus.....	6	163,999	53	47
Dallas.....	13	329,287	70	30
Denver.....	7	187,340	83	17
Indianapolis.....	6	228,340	98	2
Kansas City, Mo.....	20	248,711	60	40
Louisville.....	7	397,873	98	2
Minneapolis.....	8	214,812	80	20
New Orleans.....	12	816,022	59	41
Providence.....	8	211,185	17	83
Richmond.....	5	157,118	99	1
St. Paul.....	6	184,734	66	34
Less than 250,000 population:				
Canton.....	2	14,733	6	94
Des Moines.....	4	83,565	78	22
Duluth.....	4	35,521	84	16
Grand Rapids.....	7	53,572	68	32
New Haven.....	9	149,191	8	92
Omaha.....	6	102,435	34	66
Sioux City.....	3	32,292	94	6
Springfield, Mass.....	8	51,424	61	39
Syracuse.....	4	137,079	24	76
Wichita.....	2	87,134	100	.....
Wilkes-Barre.....	8	85,945	19	81

persons residing outside the area, direct comparisons with population figures for each area have not been made.

Among the individual areas there was much variation in the distribution of total clinic visits

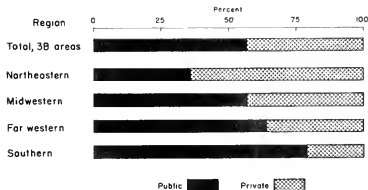
between public and private agencies (table 2). 7/

7/ In some areas it is known that clinic services are operated under an arrangement whereby public and private agencies are jointly responsible. In all cases the classification of agencies as public or private has been made on the type of administration and not on the source of financial support.

In 17 areas more than two-thirds of the visits were made to public clinics. In 4 of these the public services accounted for all, or almost all, of the visits. At the other extreme there were 7 areas where the volume of service provided by private agencies more than doubled that by public agencies. Canton reported the highest proportion (94 percent) of total clinic services under private auspices.

In figure 2 the distribution of clinic visits by auspices of reporting agencies is shown for the

FIG 2.—PERCENTAGE DISTRIBUTION OF CLINIC VISITS BY AUSPICES OF AGENCY, 38 URBAN AREAS GROUPED ACCORDING TO REGION, 1940



38 areas grouped by 4 geographic regions. 8/ Only in the northeastern region was the larger part (64 percent) of the visits made to clinics under private auspices. In the southern region, on the other hand, 79 percent of the total visits were reported by public agencies.

8/ The grouping of the areas by regions was made as follows: Northeastern region—Baltimore, Buffalo, New Haven, Pittsburgh, Providence, Springfield (Mass.), Syracuse, Washington (D.C.), and Wilkes-Barre; southern region—Atlanta, Birmingham, Dallas, Houston, Louisville, New Orleans, and Richmond; midwestern region—Akron, Canton, Chicago, Cincinnati, Cleveland, Columbus, Des Moines, Detroit, Duluth, Grand Rapids, Indianapolis, Kansas City (Mo.), Milwaukee, Minneapolis, Omaha, St. Louis, St. Paul, Sioux City, and Wichita; far western region—Denver, Los Angeles, and San Francisco.

Number of Visits and Cost of Clinic Service.

As a result of a special study in a number of urban areas certain related data on expenditures and visits to clinics are available for 28 of these areas for the year 1940. 9/ In the interest of having this special study cover as nearly as possible the total service provided in each area to residents of the area, it was requested that reports be obtained from agencies not submitting service statistics currently and also that the number of visits and costs of service provided to non-residents be excluded from the reports. In the clinic field about one-fifth of the agencies included were reported to serve an area larger than the urban area designated for the study. Estimates, usually based on the number of admissions by place of residence, were used where actual figures were not available to give the desired data.

The total expenditures for clinic service in the 28 urban areas during 1940 amounted to 56 cents per capita. With payments by persons receiving service excluded, the per capita expenditure for providing free clinic care was 47 cents. Of this, 29 cents was paid from public funds.

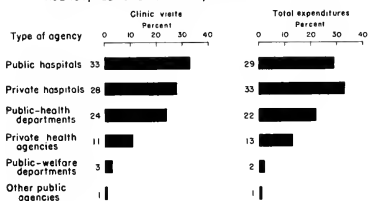
The average cost per visit including payments by patients was 82 cents for all types of agencies combined. For visits to public and private outpatient departments together the average unit cost

9/ These reports were submitted in connection with The Community Welfare Picture in 34 Urban Areas, 1940 (Children's Bureau, Washington, June 1941). Reports of clinics of the types covered in the present article and reports of separately organized mental-hygiene clinics were combined in the published report of that study. In the present article expenditures of the latter type of clinic are excluded.

was found to be the same (81 cents) as that found in the National Health Inventory of 1936. 10/

Differences in the relative size of the program as measured by expenditures and visits are shown in the analysis by type of agency (figure 3)

FIG. 3—PERCENTAGE DISTRIBUTION OF CLINIC VISITS AND EXPENDITURES FOR CLINIC SERVICE, BY TYPE OF AGENCY, 28 URBAN AREAS, 1940

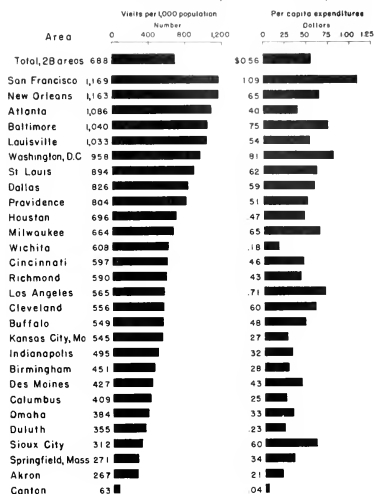


and by area (figure 4). These differences are due, of course, to variations in the content of program, in personnel practices, and other important factors which affect the cost per visit and which cannot be sufficiently weighed in a general survey. The figures indicate the need for caution, however, in measuring the size of a program by the two methods of number of visits and of amount of expenditures.

In table 3 (p.18) the expenditures reported by each area for clinic services during 1940 are analyzed by source of funds. In all but 6 of the areas more than 80 percent of the expenditures were accounted for by public appropriations and funds

10/ Plumley, Margaret Lovell: Out-Patient Operating Costs, in Modern Hospital, Vol. 49, No. 6 (December 1937).

FIG. 4—CLINIC VISITS PER 1,000 POPULATION AND EXPENDITURES PER CAPITA FOR CLINIC SERVICE, 28 URBAN AREAS, 1940



from private sources other than payments by patients. Two areas reported that all clinic service of the types included in this study was provided at no cost to patients, and in 4 other areas at least 95 percent of the service was provided in this manner.

The areas differed widely in the use of funds from public and private sources. In the majority, however, public funds were used to the greater extent. One area, Wichita, reported that all funds for clinic service came from public sources, and 4 other areas reported that public funds accounted for more than 75 percent of all their expenditures.

Table 3.—Percentage distribution of expenditures by source of funds and by area; 28 urban areas, 1940

Urban area	Total expenditures	Payments by persons receiving service	Funds from public and private sources		
			Total	Public funds	Private funds
Total, 28 areas	100	17	83	52	31
Akron.....	100	12	88	19	69
Atlanta.....	100	5	95	70	25
Baltimore.....	100	31	69	21	48
Birmingham.....	100	12	88	73	15
Buffalo.....	100	8	92	59	33
Canton.....	100	1	99	16	83
Cincinnati.....	100	11	89	40	49
Cleveland.....	100	21	79	28	51
Columbus.....	100	28	72	34	38
Dallas.....	100	17	83	25	58
Des Moines.....	100	3	97	76	21
Duluth.....	100	4	96	48	48
Houston.....	100	14	86	61	25
Indianapolis.....	100	9	91	89	2
Kansas City, Mo.....	100	9	91	29	62
Los Angeles.....	100	14	86	67	19
Louisville.....	100	7	93	83	5
Milwaukee.....	100	13	87	52	35
New Orleans.....	100	19	81	44	37
Omaha.....	100	25	75	18	57
Providence.....	100	25	75	15	60
Richmond.....	100	17	83	67	16
St. Louis.....	100	18	82	47	35
San Francisco.....	100	27	73	45	28
Sioux City.....	100	.....	100	91	9
Springfield, Mass.....	100	17	83	56	27
Washington, D. C.....	100	16	84	69	15
Wichita.....	100	100	100

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The CHILD

*** Monthly Bulletin ***



(Courtesy of Virginia State Health Department)

CHILD CONVALESCING FROM RHEUMATIC FEVER

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

JANUARY 1912



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

A Message From the Chief of the Children's Bureau

WITH UNSWERVING purpose and unbroken unity, our Nation is now engaged in a mighty effort to defend the persons, the homes, and the liberties of its citizens, and to uphold the cause of freedom everywhere.

Although our task is world-wide, the objectives of the free nations of the world center in the homes of their citizens. It is in the home, above all, that children grow into free, responsible, and effective individuals. Defense of our homes and our children is the heart of our struggle. For their safety, our home-defense organization is responsible.

We must be ever alert to the hidden as well as the obvious dangers which may jeopardize the safety, the health, the emotional stability, and the social effectiveness of our children. Fear, anxiety, insecurity are likely to be far more serious than bombs, and the responsibility for their prevention lies chiefly in the hands of parents and other adults who come in daily contact with children. Their first defense task is to achieve such inner strength and self-control as to impart security and confidence to the children who depend on them for guidance and example.

Beyond this, community services for safeguarding health, home life, education, and general well-being are necessary and must receive sufficient support in money and personnel to afford vital protection. Hard-won standards for keeping children from harmful toil must be maintained, housing shortages in defense communities must be overcome, breadwinners must have ready access to employment opportunity, for the sake both of their families and of the productive capacity of the Nation; health supervision, medical care, schooling, recreational opportunity, must be generally available.

Children suffering from special handicaps must be cared for adequately and given protection.

All these tasks must be carried on under conditions requiring unprecedented concentration of human and material resources on military objectives.

They therefore require maximum coordination of organized programs and utilization of both professional and volunteer effort. Every State and local defense council must make sure that means are provided for full consideration of the needs of children and for coordinated action necessary to secure their safety and well-being. State and local, public and private, services for children must be studied, developed to a high level of efficiency, and geared into general plans which, to the fullest extent possible, will cover total need.

Through the Children's Bureau in cooperation with the Office of Civilian Defense, the Office of Defense Health and Welfare Services, and many other agencies, the Federal Government is laying foundations for the protection of children in the event of air raids, for the day care of children of working mothers, for the training of volunteers in child care, and for other activities relating to children. We shall find increasingly how much we need everywhere available those services which are necessary for a healthy, well-prepared, happy childhood.

"Our Concern Every Child" must be our watchword. As our President has said:

All Americans want this country to be a place where children can live in safety and grow in understanding of the part that they are going to play in the future of our American Nation.

If anywhere in the country any child lacks opportunity for home life, for health protection, for education, for moral or spiritual development, the strength of the Nation and its ability to cherish and advance the principles of democracy are thereby weakened.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Children and Defense

The Office of Civilian Defense, on December 10, released a statement which includes the following advice to parents in connection with the war situation:

Your children know there is a war. They will keep cool if you do. You will keep up their morale best if you keep family life going along as usual. Try not to talk too much about the war, or listen to too much war news, especially at meal times.

The best thing for children is to have real and useful things to do that will make them feel that they, too, are serving. They can help the Red Cross by knitting afghan squares, caps, and sweaters. They can sew their own name tags into their clothing.

They can get busy collecting paper, scrap iron, tin foil, and other needed waste materials. They can turn out unnecessary lights to save the electricity. You would be wise to give each child some small special duty at home.

This will give the child a real feeling of responsibility. Let the child make beds, wash dishes, sweep, dust, prepare vegetables for cooking, cook lunch, or carry on some other practical job and do it regularly. Then help the child to feel that this is an important contribution to defense.

The most important thing of all is to make your children self-sufficient. They should as

early as possible be able to feed themselves, dress themselves, know their names and addresses and how to get home. **ABOVE ALL, KEEP THE CHILDREN BUSY AT REAL THINGS THAT THEY FEEL ARE IMPORTANT.** This, more than anything else, will keep them free from fear and panic.

* * * *

The Child Welfare League of America, on December 12, sent the following message to its members in reply to questions about war-time needs of children. These suggestions were offered for guidance pending definite instructions from State or Federal defense authorities and pending a meeting of the Board of Directors of the Child Welfare League of America:

1. Remember that unplanned or even necessary evacuation may cause serious hardship for children and families. Stand by for advice from the Office of Civilian Defense. This office is making plans for the protection of children in cooperation with the Children's Bureau and the Office of Defense Health and Welfare Services. If evacuation is to be undertaken, planning is essential. Whether or not evacuation is decided upon, the protection of the health, welfare, and safety of children should be given continuing and concentrated attention. It may be a long war and all that we do must be planned with this in mind.

2. Foster parents should consider themselves as fully responsible for the care and safety of the children now living with them in the same way as if they were their own children, and this responsibility should be maintained throughout the emergency or until discharge is arranged for ordinary reasons. This is no time in which to increase the insecurity of children. Should directed evacuation become necessary, the family situation would be considered in the same light as other family situations.

3. Supervision of foster homes should continue under present auspices. Children and foster parents need it more than before—another reason for staying where we are. If

foster parents do move, children should go with them and supervision should be transferred, except in cases in which the place to which the foster parents are going is unsafe for children.

4. Evacuation of institutions for children should never be undertaken except in accordance with plans developed by the civilian-defense authorities.

5. Take all possible precautions where you are and try to improve the health and training of children under your care. Help children to acquire the courage of our pioneer ancestors who fled to but not from their homes. Children will take their cues from the attitudes of their parents or foster parents.

CHICAGO, ILL., December 9, 1941.

MISS KATHARINE F. LENROOT, *Chief, Children's Bureau,
U. S. Department of Labor, Washington, D. C.*

The following statement just issued by our President, Herman Dunlap Smith: "With our country now engaged in war it is the duty, the responsibility, and the privilege of every individual and every organization to stand in readiness to serve in whatever way possible the needs of the Nation. The Illinois Children's Home and Aid Society will adapt its policies and program to meet those needs as becomes necessary in the months which lie ahead. Children bear the promise of a better world. Our task now as never before is to defend and protect them to the end that that promise shall be fulfilled."

M. K. RECKORD, *General Director,
Illinois Children's Home and Aid Society.*

A Community Program of Day Care for Children of Mothers Employed in Defense Areas

By EMMA O. LUNDBERG

Director of Special Projects, U. S. Children's Bureau

THE IMPORTANCE OF CONCERN FOR CHILDREN AS PART OF NATIONAL DEFENSE

We recognize the extreme importance of national defense and the necessity of maintaining the democratic way of life which makes successful defense imperative. Toward this end we believe that every effort should be made to safeguard home life, to strengthen family relationships, and to give parents a direct opportunity to participate in community planning.¹

Today the war emergency is making increasingly clear the urgency of measures for safeguarding the health, education, and social welfare of all children and is focusing attention on conditions which undermine family life. Defense of children demands action which will make available to all children physical and social protection, health conservation, educational opportunities, and other essentials of sound development and high morale.

In many communities in all parts of the country defense activities of various kinds have intensified the need for protection of children. Concentration of population in certain areas has resulted in overcrowding, inadequate housing, lack of necessary facilities for education and recreation, and hazards to the health of children. In all defense areas extraordinary measures must be taken to protect children from the inevitable consequences of disruption of normal home life and to insure proper sanitation, medical care, and recreational and educational facilities. Nursery education, as well as schooling for older children, should be avail-

able in all communities. Provision for developmental training of preschool children is needed especially when families live under abnormal conditions such as exist in many defense areas. Social services to families and to individual children are particularly necessary in these areas. Parent education should be promoted in order that home life may be made more secure.

EMPLOYMENT OF MOTHERS OF YOUNG CHILDREN

The needs of children for community services are intensified when large numbers of mothers are employed outside the home. With the entrance of the United States into the war there will be very rapid acceleration of the rising trend of employment of women. It is essential that full consideration be given to the children whose mothers may seek to enter gainful employment, and that community programs be developed to assure children whose mothers enter industry a full measure of protection and care.

The Children's Bureau Conference on Day Care of Children of Working Mothers emphasized the importance of due consideration of the welfare of mothers and children at every point in the development of employment policies relating to national defense, and stated that "mothers who remain at home to provide care for children are performing an essential patriotic service in the defense program."

WHAT IS THE COMMUNITY'S RESPONSIBILITY?

The community has concern for the welfare of all its children. When a special need arises,

¹From the recommendations adopted by the Children's Bureau Conference on Day Care of Children of Working Mothers, July 31-August 1, 1941.

such as the present emergency, it is the responsibility of the community to take such steps as may be needed to safeguard family life and to protect children from dangers which may threaten them. Provision of adequate day care for children of working mothers is a definite need in many areas.

Facilities to meet normal requirements are available in some cities, and to some extent in many others, but expansion and coordination of the various forms of day care are needed. Defense industries have been established in many areas in which day-care services for children have not heretofore been required, and provision must be made for dealing with problems of child care which arise from the new conditions.

Communities in which women are employed in defense activities should take immediate steps to plan a comprehensive and unified program of day care which will insure adequate care and protection for children of working mothers.

The long-range needs of the community must be given careful consideration in planning for emergency programs. Of first importance is adherence to standards of care that are essential to the safety and welfare of the children. Facilities required for the emergency should not be so permanent in structure that they cannot be changed or discontinued when the temporary need is over.

In the past decade there has been increasing application of the principle of public aid to dependent children in their own homes and other measures for the conservation of home life, especially since the Social Security Act went into effect. Nevertheless, in many areas the amount of assistance given to families eligible for public assistance is so small that many mothers are forced to seek employment instead of depending upon inadequate grants. In connection with the provision of day care as a substitute for care of children in their own homes, it may be well to question the wisdom of the community which evades its responsibility for conserving home life and at the same time provides substitute care which may be much more expensive than proper assistance to the home.

The need for proper provision for day care of children is not confined to families for whom the community would have to provide all or part of the cost of the care. Mothers whose earnings are sufficient to pay the entire cost of substitute care for their children, and whose work is essential in defense activities, are often unable to find facilities for such care. In some communities this need has already become acute. A community plan should take into account all families which may require advice or assistance in arranging for proper care of their children.

HOW SHOULD A COMMUNITY PLAN BE DEVELOPED?

Leadership in developing a community plan for day care should be taken by some organization which represents community-wide interests. Initiative in planning might be taken by the local defense council, a council of social agencies, the local department of public welfare, the department of education, or some other local agency or group.

The first step may be a conference to consider the need for a community program of day care for children, including representatives of various interests such as the following:

- Defense council.
- Council of social agencies or similar federation (child and family-welfare and group-work departments).
- Department of public welfare.
- Department of education.
- Department of health and other agencies concerned with health.
- Recreational agencies, public and private.
- Employment service.
- Family-welfare agencies.
- Children's agencies.
- Day nurseries and nursery schools.
- Work Projects Administration family-life education centers.
- Representatives of church groups.
- Representative of labor organizations.
- Representative of employed mothers.
- Representative of industry.
- Representative of organizations of teachers of young children and of parent-teacher associations.
- Representative of civilian-defense volunteer groups.

A continuing committee entrusted with responsibility for developing the program should be small, so as to permit effective discussion and action. Members of this committee should be selected from public and private agencies directly concerned with child care, child welfare, health, education and related services, and other interested groups.

The probable need for day-care services in the community and the extent to which existing facilities meet the need must be determined. Many communities will require the services of a full-time executive to direct the studies of community needs and give leadership in developing a coordinated community program in which all agencies in a position to take part will participate.

DETERMINING THE PROBABLE NEED FOR DAY CARE IN THE COMMUNITY

Rapidly expanding defense industries and shifting conditions make it impossible to obtain an accurate picture of the provision which will have to be made, but in many communities there is ample evidence of specific needs which demand immediate action. Initial study of the situation must be followed by continuing inquiry. The program cannot be static.

The survey of the probable extent of need for day care might cover a county, a city, or a section of a city, or any other area indicated by the spread of defense employment or by the places of residence of workers. An initial study might cover a sample area in an industrial district.

The following sources of factual information and opinions concerning the number of children needing care are suggested:

- State and local defense councils.
- Personnel officers of industrial plants.
- Public employment service.
- Superintendent of schools and school principals.
- Council of social agencies.
- Public and private family and child-welfare agencies.
- Day nurseries, nursery schools, and Work Projects Administration family-life education centers.
- Health agencies.
- Housing authorities and others having information regarding housing.

- Labor organizations.
- Community leaders.

The information sought should include:

- Nature of new defense industries and of contemplated industries.
- Expansion of existing industries.
- Policies of industrial plants with respect to employment of women.
- Number of women now employed and probable number to be employed.
- Such specific data as may be available in regard to mothers of young children employed in defense industries or in related occupations.
- Instances of need for provision of day care, obtained from various agencies and individuals with first-hand knowledge of the situation.

STUDY OF EXISTING RESOURCES FOR DAY CARE

If the community already has some facilities for day care of children, the agency or committee planning a community program should ascertain what provision is being made for the various forms of day care and the practicability of expanding existing services. If the city is large enough to make this desirable, a map should be made showing the location of defense industries which expect to employ women and the location of day nurseries, nursery schools, or other facilities for day care of children.

The inquiry concerning needs and existing resources should cover the following information and such other facts as may appear to the committee to be essential in order to know how far the needs may be met by expansion of facilities and what additional equipment must be provided:

1. Day nurseries, nursery schools, play schools, and Work Projects Administration family-life education centers—for each such organization obtain the following information and indicate the quality of the service:

- (a) Name, location, governing board, or auspices under which conducted.
- (b) Director; designation or duties of each employee.
- (c) Number of children now provided for: children under 6 years; children of school age (age limit).
- (d) How many of the children now cared for have mothers who are employed in defense industries or in occupations related to defense?

(c) Could the present facilities provide for additional children; how many?

(f) Could the present facilities be expanded? If so, how could this be done, and how many additional children could be provided for?

(g) Hours during which the children are cared for; do these hours make it possible for mothers employed in defense industries to utilize the care offered? Would it be practicable to extend the hours so as to care for children of mothers so employed?

(h) Standards of care, including appraisal of plant, number and qualifications of staff, daily plan of care, health supervision, educational methods, social services.

2. Provision for day care in foster-family homes—What agency finds these homes and supervises them? How many children are now receiving this kind of day care? What is the quality of the care provided? Could this facility be expanded?

3. Provision for supervised homemaker service—Under what auspices is it conducted? What standards of work are maintained? How extensive is this service? Could it be expanded to meet new needs?

4. Provision by schools for directed activities for school children after school hours—Describe.

5. Provision by settlements or other neighborhood centers or other recreational agencies for after-school activities—Describe.

6. Estimated total number of children for whom day care could be provided through (a) the full use of existing facilities or (b) expansion or adaptation of present facilities—Specify the type of expansion or readjustment on which the estimate is based.

7. Are the existing facilities so located that use by mothers employed in defense industries would be practicable?

PLANNING A SOUND COMMUNITY PROGRAM OF DAY CARE FOR CHILDREN

After the community-wide study of probable needs and existing resources plans should be made for organizing a program of day-care services which will provide the facilities needed at all times and which will also meet increasing needs arising from defense activities.

Existing facilities should be utilized to the fullest extent. Standards necessary for the proper care of children should be maintained. Coordination of facilities is essential for the sake of economy of money and effort. The primary objective of the program should be to make the necessary services available to *all* children who require care because of the mother's employment away from home, and

to provide for each family group or for each child the particular kind of services needed.

A day-care program for children of working mothers must make provision for children of school age as well as for those of preschool age. Care and supervision must be available during the entire time of the mother's absence from the home, unless some other responsible adult is in the home during any part of this time. If industrial plants operate on two or three shifts, mothers of young children who need care outside the home should be employed only on a day shift so that their children may be cared for without undue cost to the community and without extra hazards to the health of the mothers and children. Facilities for day care of children should be readily accessible to the place of the mother's residence or near her work, preferably the former.

Community planning for day care should approach the problem from the point of view of the child as a member of a family group whose integrity must be maintained and whose rights and obligations must be safeguarded. The physical, emotional, and developmental needs of the individual child cannot be ignored without harm to child and community.

The standards of service for children in a defense area should be similar to those of established services of recognized value, and emergency services should be planned with the perspective of sustaining, developing, and improving standards of child care throughout and beyond the emergency period. The defense program should provide an opportunity for community participation in sound planning that will be of permanent value.

Emphasis should be placed upon the importance of selecting personnel, whether paid or volunteer, with the best possible qualifications of training and experience for work with children.

WHAT TYPES OF SERVICE SHOULD BE CONSIDERED IN DEVELOPING A DAY-CARE PROGRAM?

Community plans for the care and protection of children of working mothers should include as many types of day care as are required to meet the needs of children of all ages and

should be integrated with the whole community program for public and private family assistance, social services to children, health protection, education, and recreation.

Types of service which should be considered include:

1. Counseling or advisory service to mothers concerning problems related to day care.
2. Day-care centers.
3. Out-of-school programs for children of school age.
4. Foster-family day care.
5. Supervised homemaker service.

It must be determined, first, on the basis of studies of the situation in the community, how far the emergency needs can be met by existing agencies within their present capacity for service; second, what services can be expanded or readjusted to meet the new demand; third, what new types of service it will be necessary to develop.

A community program cannot be developed and cannot conform to changing needs without active guidance by a designated agency or committee. The responsible organization should provide a central place where information may be obtained in regard to care available in the community. In many communities, especially where the problem is acute and widespread, it may be necessary to employ an executive secretary with responsibility for coordinating services of agencies already operating and establishing additional services wherever indicated.

FINANCING THE DAY-CARE PROGRAM

A community program for day care cannot be effective unless there is a plan for sound financial support which will insure services of the kind needed, maintaining standards of health, education, and social service in accordance with the best practice. Planning cannot lead to constructive action unless means can be made available for adequate financing from public or private sources.

Day nurseries and other facilities for day care of children have been supported mainly by private organizations, through community chests or otherwise, part of the cost being paid

by parents of the children under care. In communities where the needs are greatly increased by the defense emergency existing day-care centers may not be able to finance additional work through their own funds or through allotments by community chests already heavily taxed to help maintain established health and welfare services. If day-care programs are to be established which will meet the needs of defense communities, it will be necessary for public funds to provide some part of the cost.

The cost of adequate care in a day-care center must be determined as part of the plan. Consideration should be given to the availability of free food supplies through surplus commodities and to the use of volunteer service supplementing paid service. The rising cost of living must be taken into account in planning the budget.

The cost of day care in foster-family homes will be influenced by the prevailing rates paid for foster-family care in the community. The cost of supervised homemaker service will also depend upon the wages paid for trained service of this kind.

The feasibility of requiring parents to pay any of the cost of day care, and the amounts they should pay, should be determined by the central planning committee or the agency responsible for providing day care. Regardless of the source or the amount of payment by parents for day care, the program must be so administered that there can be no differentiation among the children on the basis of the financial arrangements made for their care, and no identification of children receiving free or part-paid care.

Facilities such as public-school education, certain health services, and opportunities for various forms of recreation are commonly furnished without charge by the community for all who wish to avail themselves of these services. Provision for nursery education should be accepted increasingly as a responsibility of the public-school system, as well as extended use of school facilities and services for all children who may derive benefit from after-school activities. For children whose mothers cannot be in the home during the day such public serv-

ices, available without charge, are especially important.

COUNSELING SERVICE

Mothers who are working or who are considering employment should have someone to whom they can go for advice and help in planning for the care of their children. Not all situations which present themselves will be solved by the simple expedient of placing the children in a nursery center or under some other type of care available in the community. The mother must be helped to think through her problem and to make plans that will safeguard the health and welfare of her children. The entire family group and their mode of living must be considered. The community has a stake in the plans from a production as well as from a social and financial point of view.

Individual counseling service should be provided as a vital part of the case-work service which should be available to parents who need help in planning for the care of their children and those who need continued guidance and assistance in order that the welfare of their children may be assured. Such service might be provided by the central day-care office or by individual day-care centers. The decision as to the method to be used in a particular community or section of a community should be made after careful study of the best means of making the service available to parents. Social workers with case-work training and experience should be employed for this service.

DAY-CARE SERVICES²

General Considerations

Three forms of service—social welfare, health, and education—enter into all day care, whatever the type of care may be. The service given must have as its focal point the family home. The individual child cannot be given the guidance and care he needs unless there is under-

standing of the conditions under which he has lived and the home to which he returns at night. The child's parents should participate in making the plans for care and should remain in partnership with the agency providing care. This is the special responsibility of social service.

The child's health—mental as well as physical—must be considered in determining the kind of care he is to receive, and while he is under care his health must be protected. Whether the child is of nursery school or kindergarten age or of school age, the educational process which guides his development is an important part of his care. Recreation is related to the health, education, and social-service functions of day care. A program of parent-education is essential in order that there may be continuity in policies regarding the management of the child and understanding of his needs and his development from day to day.

Where day care has been established as one of the child-welfare resources of the community in ordinary times, the provision made for emergency needs should be integrated with this program and should utilize these facilities as far as possible.

The Day-Care Center

In most communities the major part of the care made available for young children whose mothers are employed in defense industries will be provided by day-care centers equipped for all-day care.

The day-care center should include the recognized features of a good day nursery, incorporating the methods and equipment of a nursery school. During the past few years day nurseries have increasingly come within this definition by adopting nursery-education methods, and recently many nursery schools have readjusted their programs so as to provide the full-day service of a day-care center.

Group care in a day-care center is particularly adapted to the needs of children 2 to 5 years of age, inclusive, the "preschool age." If the center cares for school children outside of school hours separate provision should be made for these older children.

² Following the Conference on Day Care of Children of Working Mothers, held under the auspices of the Children's Bureau, July 31-August 1, 1941, a Committee on Standards and Services for Day Care was appointed. This committee is preparing a report on standards of the various forms of care.

When a defense industry operates on two or three shifts, an effort should be made to secure arrangements whereby mothers of young children are employed during hours when they can reasonably expect to obtain care for their children. This is essential for the protection of the health of the children and of the mothers, and in order that proper care may be provided by day centers.

Before undertaking the planning of day-care facilities, there should be careful study of the regulations governing these services and the standards set up by State and local government authorities. The day-care center should conform to State and local building regulations, sanitation and fire laws, and standards governing floor space and air space. It should be licensed by the appropriate State or local department responsible for supervising this type of institution.

The staff of the day-care center, whether paid or volunteer, should be selected because they have the necessary qualifications for the work they are to do. Those who are to perform work relating to social service, health supervision, developmental training, or recreational activities should be equipped for these services by professional training and experience in work with children.

Many forms of service can be given by volunteers. If volunteers give service relating to nursery education or recreational activities they should be qualified for this work by training or experience or should be directly under the supervision of professional staff.

The day-care center should carry on various forms of parent education. The social-service and nursery-education functions of the day-care center provide a natural basis for such relationship between the center and the parents of children receiving care.

Although the functions of nursery schools operating under a half-day plan are comparatively limited with respect to furnishing the care required for children whose mothers are employed long hours in defense industries, they play an important part in the varied programs of child care needed in defense areas. Working mothers who are employed only part of

the day and families in which a responsible adult in the home can care for the child outside of nursery-school hours while the mother is at work can obtain the day-care services they require in a nursery school instead of in a day-care center. The counseling service of the community plan should take into account the needs in each situation.

Facilities for After-School Care

Care and supervision of children of working mothers should be available not only for children of preschool age, but for children of all ages. When a mother who is employed or is contemplating employment comes to the attention of the counseling service attached to the central office of the day-care community program, or when application is received by a day nursery or other agency, it should be the responsibility of this office or agency to assure itself that all children of the family will have proper care and supervision during the mother's absence from home.

Children of different age groups require varying types of provision for after-school care. Day nurseries or other day-care centers frequently look after children from 6 to 10 or 12 years of age, during the time when school is not in session. If they have proper space and equipment to give these older children an opportunity for wholesome activities without undue disturbance of the program for preschool children such care should be made available, especially when it seems desirable that all children of one family should be cared for in one place. When a neighborhood house or other center of this kind is located near a day-care center which cares for young children, a very desirable plan may be worked out for the after-school activities of the older children. Schools, churches, clubs, and recreation centers have an opportunity to perform a constructive service in making facilities available to children of school age.

The major responsibility for safeguarding children of school age falls naturally to the public and private schools of the community. Schools located in neighborhoods where considerable numbers of working mothers live

should be equipped for after-school activities of various kinds which will appeal to children of grade-school ages, and to older groups of boys and girls.

For after-school programs schools should be equipped for both indoor and outdoor activities, which should be available to the children during the hours of the mother's absence from home.

Facilities provided by schools must necessarily be available to all children who wish to make use of them, but special attention should be given to assuring the attendance of children whose mothers are not in the home. The wider use of school facilities will serve a very useful purpose in the community, other than that directly related to supervision of children of working mothers.

The success of the venture will depend upon the quality of the staff under whose guidance the children work and play. A sufficiently large professional staff should be employed to direct activities for which they have special training and experience. Volunteers can be used in a variety of activities; they should be given special training for specific services. Unless volunteers have had professional experience they should be used as assistants to the paid staff and not as substitutes in positions requiring professional skills.

Whether after-school programs are provided by the schools themselves or by a day-care center or another organization, the important thing is that somebody should be responsible for seeing that the children of employed mothers are getting the individual attention required. An after-school program for these children means much more than merely providing for recreation or other types of activities. If schools undertake this function the necessary provision must be made for the physical care of the children, with special attention given to the needs of young children during all of the hours of the mother's absence from home. Social service and parent education must be an integral part of an after-school program for children of working mothers.

Day Care of Children in Foster-Family Homes

The Conference on Day Care of Children of Working Mothers held under the auspices of the Children's Bureau of the United States Department of Labor included the following statement in its recommendations: "Infants should be given individual care, preferably in their own homes and by their own mothers." When it is necessary to provide care for children under 2 years of age away from their own homes, the most suitable form of care is placement for day care in a foster-family home. Health hazards involved are such, however, that care away from the child's own home should not be resorted to without special safeguards.

Foster-family day care is desirable for children under 2 years of age and over who will do better under individual care than as members of a group. This form of care may be useful when the family lives at some distance from a day-care center. Several children of various ages in one family may be cared for together in a foster-family home which serves as a substitute for their own home during the mother's absence.

When possible, arrangements should be made to have preschool children in the care of foster families attend a nursery school just as their older brothers and sisters will attend school.

Foster-family day care as yet has been developed extensively by social agencies in only a small number of communities, but indications are that it will be used increasingly as a community resource for the care of children of working mothers. In the absence of provision by recognized agencies, many working mothers will doubtless continue to make their own arrangements for this type of care. Community plans for day care of children should include provision for assisting these mothers to find suitable foster-family homes. So far as possible, however, resources for day care in foster-family homes should be developed by established social agencies in the community, thus providing needed case-work service and safeguarding the health of the children.

Homes caring for children on a day basis that are not under the supervision of an authorized agency should be subject to annual licensing and to supervision by the appropriate State or local department. Standards recognized by child-placing agencies as essential to home-finding and to supervision of foster-family care should be applied to day-time care in foster-family homes. When facilities for day care in foster-family homes are developed by child-welfare agencies these standards should be assured.

The selection and supervision of foster-family homes require special skill. The situation with respect to independent placements is difficult, but much can be done through counseling service provided by the central office of the community day-care program or by child-welfare agencies in helping mothers who come to them for advice. Such advisory service should be available to families considering day care of their children by foster families.

Supervised Homemaker Service

Supervised homemaker service has been developed in a number of cities to provide services when the mother is absent from the home or when she is in the home but because of illness or for some other reason is unable to give proper care to her children. This service is provided by family-welfare or child-welfare agencies and is made available to families with low incomes who need service in order to keep the home intact while it lacks a mother's care. Homemakers are carefully selected and trained for the service which they are to give, and work under the direction of the agency which also provides case-work service needed by the family.

By this plan the children have the continuity of care and the security which their own home can afford and their usual living habits are maintained.

Homemaker service can make a significant contribution to a day-care program. When a child is sick and unable to go to a day-care center, foster home, or school, care in his own home should be made available, as otherwise the mother would have to leave her work.

This service is expensive and would probably have to be developed mainly on a self-sustaining basis. Development of homemaker service should be considered particularly as a method of meeting the needs of professional or business women and others with a sufficient salary to afford adequate service.

The use of supervised homemaker service may be indicated in some situations where the family can pay only part of the cost of the service, and it may be useful in meeting some types of emergencies. Plans may well be made to send preschool children to a nursery school for part of each day.

Training of the "homemakers" must be supplied by an experienced agency which also supervises their activities. Facilities for training for this service should be developed in communities in which it can be carried on successfully.

STATE AND FEDERAL LEADERSHIP

Federal and State agencies and National organizations have a continuing responsibility for exerting leadership in upholding standards of child care. These agencies have the further responsibility of stimulating action by local communities and assisting them in their efforts to meet the increased demands for care and protection of children which have grown out of or have been augmented by the expansion of defense activities.²

Official agencies in a number of States have recognized the necessity for State assistance in planning community programs of day care for children in defense areas. In several States the department of public welfare or some other State department is studying the needs of defense communities and helping them to plan programs of day care. Such action is essential especially in States where there are a number of defense areas. In Connecticut and Utah, and perhaps also in some other States, leadership has been assumed by a social-welfare committee of the State Defense Council.

Whether the responsibility for State action is centered in one of the existing State agencies

² From the recommendations adopted by the Children's Bureau Conference on Day Care of Children of Working Mothers, July 31-August 1, 1941.

or in an official organization created for this special purpose, it is desirable that the State planning group shall include representation from the State departments of welfare, health, education, and labor and from the State Defense Council. State-wide organizations which can make a contribution to the work of the State committee on day care should also be included, as well as representatives of councils of social agencies or other community-wide organizations in cities in which there is likely to be need for special provision for children of working mothers.

The State department or committee should inform itself concerning the need for provision of day care for children in defense areas throughout the State in order that it may be in a position to stimulate local action.

It should assist communities in their efforts to meet increased demands for care and protection of children, which have grown out of or been intensified by expansion of defense activities.

It should prepare material which may be of service to local communities, such as basic standards of care, and should interest itself in enactment of such statutory measures as may be required for the protection of children.

It should maintain a relationship to local developments which will insure the provision of proper facilities for day care and which will promote the essential defense activities of the State.

The State department or committee which assumes leadership in helping communities plan a coordinated day-care program must be alert to the dangers of unregulated day-care activities by individuals or groups which are not equipped to provide safe care for children. Day nurseries, nursery schools, and play centers are springing up overnight like mushrooms in many communities, sometimes activated by

purely commercial motives. The State departments of welfare, health, and education must be enabled to fulfill their responsibilities for safeguarding children who require day-care service. These three agencies of the State should act in harmony for the protection of children.

A program of day care for children cannot be developed as a separate program, but must be related to other services providing health protection, educational opportunities, recreation, and social service. Federal agencies carrying programs of cooperation with the States in extending and strengthening these basic services are planning together concerning the special problems of care and supervision of children whose mothers are employed in defense areas and methods of utilizing to the fullest extent the Federal and State resources available within the local communities. However, because no two communities have exactly the same problems, primary responsibility for initiating and directing programs in the emergency must remain with the local communities.

Programs designed to meet the emergency needs of this period should be planned with a long-range view. The services inaugurated as urgent defense measures should not stand in the way of the development of other forms of social provision which are essential to conservation of home life and the welfare of individual children. Day-care programs should be re-evaluated from time to time and revised in the light of new requirements. Needs are not likely to be static, and methods devised to deal with the needs must be subject to change. Some of the facilities which are urgently required now will be discontinued or turned to other uses when the emergency is over; others will be found permanently useful to the community. The day-care program should take into account future values as well as present needs.

Defense Pressure Focuses Attention on Child Problems¹

BY RUTH ALESHIRE

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The effects of the emergency defense program and its ramifications in social planning have been so adequately discussed it is not necessary to elaborate further in this brief article. We have accepted the fact that housing, recreation, health, education, and related problems have been more sharply focused in these areas. Sudden spurts of employment have changed some provincial rural localities into densely populated communities. The influx of laborers, prospectors, families of men in military service, and a loosely defined group of persons who "just came along for the ride"—families who have no actual plan for maintenance or continuing as a cohesive group—invariably involve complexities which result in exploitation and neglect of children. What child-welfare workers are concerned about is: "How does this vacillating community picture, which is in reality a panorama, affect the lives of children?"

Can we not proceed on the general premise that the basic needs of children remain the same regardless of the environmental changes—and go even further by saying that the department of public welfare exists fundamentally to meet these needs? If there is a multiplicity of and variation in these basic needs, is it not possible that the agency must enlarge its personnel and expand its functions? Surely the solution of child-welfare problems in defense areas will not be a procedural one. Merely to resort to the hackneyed "they don't belong here, so send them back" will engulf the agency in a whirlpool and perhaps in a slow and painful drowning over a period of several years.

The local department of public welfare as the parent agency will essentially be interested in other agencies—those which are coming into the community for the first time and those which are supplementing an already established function. The United Service Organization, the Red Cross, and local private agencies are already trying to define and redefine their functions as related to existing needs. Yet the department of public welfare must accept realistically the fact that orientation for them will be a more simplified process than for an entirely new agency coming into the community or for the established agency with a more strict limitation of function.

The increase in the number of abandoned children, unmarried mothers, delinquent adolescents, and children requiring temporary placement plans has not been unexpected. Often it is necessary to jolt people from their lethargy and optimistic enthusiasm about "more employment and better times" by pointing out that these situations are concomitant with boom towns, transiency, and unstable family life wherever it is found.

The department of public welfare, then, may see its responsibility as:

1. Assuming leadership in an evaluation of community resources in light of the present, and perhaps future, situation, and helping in every way possible to integrate these resources and mutual objectives. Actually the department of public welfare must be the standard-setting agency—it is accepted by the community; it has been established over a period of years; its structural framework is broad.

2. An acceptance of the democratic philosophy that all children are vitally important and the mechanism of the agency should not become top-heavy for any special group. The rural child who has been known to the agency for a period of years is just as important as the waif who has toured 14 different States

¹Reprinted from *Public Welfare News*, Vol. 4, No. 2 (November 1941), by permission of North Carolina State Board of Charities and Public Welfare, Raleigh, N. C.

during the last year and is finally dramatically deserted in a trailer camp. It is the child's inalienable right to have case-work service of the highest quality when hazards over which he has no control deprive him of family care and protection.

3. Expanding and supplementing the agency resources now in use for children's work. For the agency accustomed to a boarding-home program as an integral part of its program and cognizant of its inherent values, the worker will not be too frustrated at the increased need for this special service. For the agency which has a well-defined relationship with the juvenile court and uses this relationship as a constructive tool in the problems of delinquent adoles-

cents, the worker need not be too distraught by the increase in cases of young girls who have come to a community only to find themselves without funds or friends—now ready for exploitation or for understanding and guidance.

Actually the structure of the department of public welfare must not be revamped for an emergency situation which proves colorful and challenging because of its very dynamics; rather it must reassure itself that each individual child is so important that his well-being must be cherished and safeguarded in the regular day-by-day job.

BOOK NOTES

PROTECTION OF CHILDREN IN GREAT BRITAIN IN WARTIME, by Martha M. Eliot, M. D. *American Journal of Public Health*, Vol. 31, No. 11 (November 1941), pp. 1128-1134.

Dr. Eliot, Associate Chief of the Children's Bureau, in this address given at a special session of the American Public Health Association in Atlantic City, N. J., October 17, 1941, describes measures taken in Great Britain for the protection of children in cities under bombing and for the evacuation of children to areas of comparative safety. Dr. Eliot was a member of the Mission of Civil Defense which visited England in February 1941.

Single copies of reprints of this article can be obtained from the Children's Bureau while the supply lasts.

GAMES THE WORLD AROUND, by Sarah Ethridge Hunt and Ethel Cain. A. S. Barnes & Co., New York, 1941. 268 pp. \$2.50.

Children the world over play, and whether a child lives in the slums of New York, the jungles of Borneo, or on the fjords of Norway he will be found playing games that have amazing similarity. A child, regardless of his race, creed, or color, likes to run, chase, hide, and compete in games of skill and chance. Each land makes use of the things at hand but the fundamental pattern of play is universal.

Sharing of enjoyment is an experience which leads to friendship and understanding and oneness with the other group. It helps develop a tolerance toward differences discovered later.

Games The World Around puts into the hands of recreation leaders a means by which children could be given a feeling of familiarity with the children of other

lands. It is a compilation of games from 35 countries. It is arranged by the country of origin of the game, but indexes make possible the easy selecting of games according to the age level to which the game appeals, the type of activity, whether active or quiet, and the kind of place available for play.

The games can be played just as games, or they can be played as dramatized experiences of the foreign children. The book contains, by means of both words and pictures, many suggestions of simple equipment and costumes which would do much to create the atmosphere of the country in which the game had its origin, a coconut, for example, instead of a ball, or a Turkish fez, or a Hawaiian grass skirt.

The book's value is in the help it gives to find a means of developing in our children a tolerance and understanding for other peoples.

IT'S FUN TO MAKE THINGS, by Martha Parkhill and Dorothy Spaeth. A. S. Barnes & Co., New York, 1941. 176 pp. \$2.

The things made at the Crater Club Day Camp were fun to make. The owners of the camp, Martha Parkhill and Dorothy Spaeth, have written down the instructions for making these things. The instructions are explicit and brief. There are working drawings for many articles and pictures of many of the finished products. Most of the things are made out of very inexpensive materials, and in many cases out of things ordinarily discarded. When purchased materials are needed the authors have included information as to just what to buy, where to buy it, and how much it should cost.

The articles described are painted articles, metal objects, wooden things, sewed things, pottery, leather articles, things made from raffia, and some others.

• **BIRTH** •

• **GROWTH** •

• **CHILD HEALTH** •

The Virginia Program for Children With Rheumatic Fever

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The Virginia State program for children with rheumatic fever and heart disease, put into operation May 1, 1940, has been developed and administered in accordance with the general policies outlined by the Children's Bureau Advisory Committee on Services for Crippled Children. From the beginning it was decided to develop services for only a small area of the State so that even with a limited budget the service extended to the individual child might be complete.

The program is administered under the Crippled Children's Bureau of the State Department of Health. The full-time services of a pediatrician who is the director, a public-health-nursing consultant, a medical-social consultant, a clerk, and the part-time consultant services of a cardiologist are paid for by the Crippled Children's Bureau; the part-time services of a technician are paid for by the Medical College of Virginia.

All children under 21 years of age are eligible for clinic examination and follow-up, and all children under 16 years of age who are in need of the services are also eligible for hospital and convalescent-home care. A patient accepted before his sixteenth birthday remains eligible for care until he reaches the age of 21 years. Because of limited budget, preference is given to cases of rheumatic fever and heart disease with a fair prognosis of reasonable rehabilitation. For the first year of our program,

patients were accepted from the City of Richmond and the surrounding Henrico County. Beginning July 1, 1941, increased appropriations were made, and two additional counties were included in the program.

The program started with a long list of cases of rheumatic fever or heart disease gleaned from the files of the Medical College of Virginia Out-Patient Department and Hospital Division. Private physicians as well as school, city, and clinic physicians and all the local nursing and social agencies were informed concerning the program and asked to refer cases. All children, except in emergency, are seen by appointment only. If a private physician refers a child for service, he specifies whether he wishes his patient to receive diagnostic service only or complete care. Through this procedure possible misunderstandings on the part of the physician, the patient's family, and the clinic staff are avoided. Following examination in the clinic, a prompt and detailed report is sent to the referring physician.

Clinics are held twice a week in the Out-Patient Department of the Medical College of Virginia. Eight patients are seen at each clinic session, some of them new patients, some of them old. The pediatrician conducts the clinic and examines every patient. In a clinic of this size it is possible to examine each child thoroughly and to utilize special diagnostic procedures as indicated—fluoroscopic or electrocardiographic

examinations, X-rays, clinical laboratory examinations, and special clinical consultations. Arrangements were made for these services, with the exception of X-rays and electrocardiograms, in return for a flat clinic fee paid by the Crippled Children's Bureau to the Medical College of Virginia. Special cases and certain new cases are seen by the consulting cardiologist, upon request of the pediatrician, in the clinic, hospital, convalescent homes, and the patients' own homes. The resident in pediatrics in the Medical College of Virginia also works in the clinic under the immediate supervision of the pediatrician.

Since the meticulous "workup," which has just been described, necessarily means that each patient must stay for a fairly long time, effort has been made with considerable success to see that the patient does not become tired, nervous, or bored. Immediately after registration the patient is taken to an individual examining room where he is undressed. Then the clinic nurse determines the height, weight, rectal temperature, blood pressure, and vital capacity. The technician collects blood for sedimentation and other tests, taking care to explain to each child just what she is going to do. In this way apprehension is lessened and confidence is established on the part of the child. The child then either naps or reads until the examiner enters his room.

The public-health-nursing consultant and the medical-social consultant are present at the clinic. The public-health-nursing consultant uses the opportunities afforded by the clinic to familiarize herself with the health problems of the patients and their families and to help them deal with these problems. Since she is present at the medical examination of the children and thus has direct knowledge of the medical problems and the instructions given to the children and their relatives, she is able to interpret the instructions to the families and also to the local public-health nurses who give nursing care and health instruction in the homes. Attendance at the clinic enables the medical-social consultant to help the families with social problems related to the medical condition and to participate in plans for the

child whenever social situations affect the medical plan.

Before a child meets his appointment at the clinic, the medical-social worker has gathered together, either from reports provided by social agencies interested in the family or from data secured personally by visiting the child's home, information concerning the patient's family and environment, including any indications of the family's resourcefulness and probable adaptability in providing for both the physical and emotional needs of a sick child. This information is made available to the pediatrician when the child comes to the clinic. The medical-social consultant, in turn, learns at the clinic about the specific medical problem and is thus able to relate the medical and social factors affecting the child's care in order to help the social agencies in the community understand the social implications of the medical condition, and to work with other members of the professional staff and with the social agencies in making an effective plan for the child's care.

Acutely ill patients are hospitalized in the pediatric ward of the Medical College of Virginia Hospital Division, where they remain under the care of the pediatrician on the State rheumatic-fever program.

After the more acute symptoms have subsided and care in the general hospital is no longer necessary or desirable, the children usually require a long period of bed rest, and during this period they still need medical, nursing, and medical-social supervision. The pediatrician, medical-social consultant, and public-health-nursing consultant decide, on the basis of their knowledge of the home situation, whether the needs of the child can be satisfactorily met at home or whether convalescent care in an institution is preferable.

If the home is, or can be made, adequate for the purpose, the child is transferred to his home. There, he is visited as often as necessary by the pediatrician.

The public-health-nursing consultant makes arrangements for his nursing care by local public-health nurses and gives consultation service concerning this care. Within the city limits

the nurses of the Instructive Visiting Nurses' Association furnish bedside care and nursing supervision, visiting the home two or three times weekly. In the surrounding counties the county public-health nurses visit the homes as often as possible and give nursing supervision. In either case the nurses are sent information concerning the patient by the public-health-nursing consultant on the State staff. In turn, detailed reports are sent back to her on mimeographed forms which she has worked out in cooperation with the other members of the professional staff.

It is the responsibility of the medical-social consultant to supervise the child's care from the social point of view and to give assistance needed to adjust social and environmental difficulties, either directly or by consultation with social agencies in the community. All social agencies carrying responsibility for any services to these children or their families are kept currently informed of the child's progress and of any changes in the medical recommendations that have implications for the child's care and adjustment in his own home. Reports of developments in the home situation received from the social agencies, may, in turn, contain significant social data having a direct bearing on the medical plans.

Through the Richmond public-school system plans have been completed recently for securing a home teacher for children under care who live within the city limits.

If the home cannot be made suitable for convalescent care, as is often the case, this care is provided in one of two convalescent units. Prior to the initiation of this program, no such unit was available. Arrangements were made immediately with the Crippled Children's Hospital to provide beds for eight white children. For some months these children were cared for in the orthopedic wards. It was found, however, that this was an unsatisfactory arrangement. Children convalescing from rheumatic fever are likely either to be stimulated to hyperactivity or to be depressed or antagonized when placed in the midst of a boisterous ward. The very activities encouraged in many orthopedic cases (manipulation of hand carts and occupational therapy requiring strength and resist-

ance) are not desirable in the early convalescent stage of rheumatic fever. Also there are inevitably more opportunities for exposure to infections of the upper respiratory tract.

Therefore, arrangements were made for the exclusive use of a unit of four small rooms and bath where the patients might live but from which their beds or chairs might be rolled to the schoolroom and occupational-therapy shop. This is proving to be a good arrangement. It allows for a wider range in the selection of cases, since by wise grouping of patients we can limit activities markedly or increase them to any degree. Work is now being done in cooperation with the occupational-therapy department on a program of graded activity for these children.

Since no convalescent facilities were available for Negro children in Richmond, arrangements were made with a small private hospital for Negroes to care for eight convalescing children in two large, sunny rooms with bath. This was a new project for the nursing staff of this institution and has required a great deal of supervision. It was discovered that in a general hospital such as this, staffed by graduate nurses whose experience with rheumatic fever is extremely limited, conscientious and understanding care of this special group is best obtained by having two nurses on alternate duty rather than by allowing routine rotation of duty by all the nurses. Nurses on general floor duty who are not well informed in regard to rheumatic fever are likely to interpret orders for rest and exercise rather loosely. Moreover, they usually cannot take the time for the health instruction and supervision essential for good care. It was also noted that it is seldom a good arrangement to place three children in one room. Either a smaller group or a larger one is more satisfactory. Very often, in a group of three, the youngest or "slowest" is "picked on" by the other two. In a small, partly isolated group it is extremely difficult to care for children in varying stages of the disease. Since they live so closely together it is easy for the "too well" child to depress or overstimulate the others and for the "too sick" child to feel unhappy and dissatisfied. This situation is

largely avoided in a large ward or in a ward with many small units allowing for wise grouping of patients.

The employment of a young, inexperienced occupational therapist and teacher, even though she was a very intelligent woman, proved unsatisfactory. The teacher must be sufficiently mature and experienced both to get the children's cooperation and to instruct them. This avoids needless conflicts and emotional strain. A great change has been noted in the physical condition and mental attitude of this group of patients since such a person has been obtained through the Department of Education of the Work Projects Administration.

Visiting by parents and older family members is encouraged in both convalescent units. Younger brothers and sisters, when free from respiratory infections and sore throats, are also allowed to visit on the lawns. It is felt that in dealing with children with a long-continued illness every reasonable effort must be made to strengthen the home tie, even at the expense of a few risks, rather than to allow it to weaken.

The technician visits the convalescent units for routine laboratory work. It is planned to purchase a portable cardiette so that the pediatrician may obtain electrocardiograms in these units and in the children's own homes as well.

The child is discharged from the convalescent unit only when the rheumatic infection has become entirely inactive, except when a different plan of care is decided upon for medical or social reasons. Before he is sent home, his home situation is carefully studied and help is given by the medical-social consultant and the public-health-nursing consultant, either directly or through local social and public-health-nursing agencies, in making necessary adjustments in the home to improve social and health conditions.

After the child returns home, he is watched carefully for any recurrence of rheumatic infection. The child reports to the clinic every 1 to 3 months for medical examination. The public-health-nursing consultant arranges to have a public-health-nursing visit made to the home about once a month for health supervision and education. This is usually done by

the city department of health nurse. The medical-social consultant continues to be on the alert for social situations which might hinder the child's proper care. Information regarding the school child is sent promptly to the school principal and school nurse to protect him not only from undue exposure to colds and unwise activities but also from oversolicitude.

Since a child being cared for under this program may have a medical record in as many as three centers (hospital, convalescent unit, and clinic) it is considered advisable to keep a complete chart in the clinic files. This chart is composed of forms based on those suggested by the Children's Bureau and is kept in strict chronological order. It includes a record of clinic examinations, medical-social worker's and nurse's notes, home-visit reports, and abstracts of hospital or convalescent-home admissions. Provision is also made for a semiannual summary of the case. All correspondence pertaining to the patient is kept in the back of this folder.

The staff holds conferences twice a week to discuss medical, nursing, and social aspects of care of individual children presenting special problems and of every child scheduled to attend the clinic during the current week. By means of these conferences all the facts about the child known to the staff are pooled and a coordinated plan is made for the care of the child.

To further the interest in and information about the rheumatic-fever program, all members of the staff are available at all times for talks before interested professional, student, and citizen groups and for consultation with local agencies. Considerable emphasis has been placed on the education of medical students and nurses concerning the problems of rheumatic fever and heart disease in children, so that they might be better prepared to handle the problems when they meet them in medical and nursing practice. So that instruction of medical students need not take up time necessary for the thorough examination of patients and the interviewing of their parents, a separate time is set aside for such instruction; the

cardiologist or pediatrician selects a patient from the clinic and spends an hour in discussing the case with a group of four medical students. Care is taken not to discuss, in front of the child or his relatives, anything which might disturb them. Undergraduate nurses from the Medical College of Virginia and postgraduate public-health nurses from the Richmond Professional Institute attend the clinic singly for a month at a time. Here they are instructed by the public-health-nursing consultant on the State program in the clinic set-up and in the nursing care of children with rheumatic fever. They also attend the discussion periods with the medical students. It is not

considered wise to accept a student nurse for one or two sessions of instruction only.

Also, in anticipation of being able steadily to extend the program throughout the State, members of the staff take every opportunity to inform county health officers, public-health nurses, physicians, welfare workers, and teachers about the program and to encourage them to report all known cases of rheumatic fever and heart disease to the Crippled Children's Bureau. In some measure these reports may prove an indicator of the area most in need of service and most ready for it, and they will also furnish a working nucleus of cases when the program is extended.

Children and the National Nutrition Program

By MARJORIE M. HESELTINE

Consultant in Nutrition, Division of Health Services, U. S. Children's Bureau

The National Nutrition Conference for Defense brought together workers from many fields to consider nutrition in its broadest aspects as a national problem of this country and the other democracies. With the exception of the subdivision of Section III, which concentrated on the nutrition of pregnant and lactating women and of children, the problems of children were not dealt with separately. Yet there was no evidence at the time of the conference, nor has there been subsequently, that children were given inadequate attention. On the contrary, there seemed to be unanimous recognition that what was said in general of the importance of nutrition to individual well-being applied with even greater force to children, and that the greatest promise of improving the nutritional status of children lies through measures directed toward the betterment of the condition of family groups, to which most children belong.

The proceedings of the National Nutrition Conference are in press at the time this article is being written. Child health and welfare workers will wish to read the proceedings for

themselves. They may well be forewarned, however, that it is not enough to read a single address or the recommendations of one or two sections. Concern for the nutritional well-being of children permeates most of the deliberations. It seems fitting that the conference speaker to give most consideration to the nutritional problems of children should have been the Secretary of Labor, the member of the Cabinet who is responsible for the administration of the Children's Bureau.

Familiarity with the reports and the recommendations of the National Nutrition Conference is the first essential to understanding and evaluating the ferment of nutrition activity in almost every section of the country. For the National Nutrition Conference was of course only the opening shot in a Nation-wide campaign. Delegates came to the conference from every State and went back home to translate the recommendations into action. Representatives of great national organizations took the word back to the annual meetings of their respective professional groups. From first-hand observations in several States and from reports

from most of the others, it is possible to select instances of current activities directed toward the improvement of the nutritional status of children. It seems simplest to classify specific activities under the headings of some of the recommendations of the conference to the President.

1. *The use of the dietary allowances recommended by the National Research Council.* Leaders in the field of human nutrition have formulated a statement of dietary requirements for healthy individuals of different ages and varying degrees of activity. For the first time, then, maternal and child-health workers have a common yardstick against which to measure both the adequacy of their dietary recommendations and the actual food-consumption practices of the individuals and family groups which they reach. There is ample evidence that this yardstick is being applied generally. The dietary recommendations in the publications of the Children's Bureau are being checked against the yardstick and necessary modifications are being made in those publications now under revision. Letters and other reports received by the Bureau indicate that State health agencies and medical societies are doing likewise. That pediatric groups have been especially active along these lines is quite in character with Dr. Wilder's comment at the conference that they were first among physicians to crystallize their interest in the health problems caused or exaggerated by malnutrition. In the course of recent meetings at the Children's Bureau of the Advisory Committee on the Health Services, it was reported that obstetricians too had been checking dietary recommendations and the food intake of their patients against the new yardstick.

2. *"Translation of these allowances . . . into terms of everyday foods . . ."* All over the country groups of professional workers are following the suggestion of the nutrition conference that the recommended dietary allowances be expressed in "terms of everyday foods and appetizing meals suitable for families and individuals at different economic levels." Leadership in this activity is generally assumed by the State nutrition committee, the coordinating

agency that is at work in every State and that is represented on many State defense councils. Nutritive needs are human needs that do not vary with race, color, or length of residence. However, these needs may be met by widely different combinations of foods. In the deep South, for example, both Negroes and white persons in the lower income groups tend to get a large part of their vitamin A from dark green leaves, which they eat in larger quantities and over a longer season than families in similar circumstances in other sections of the country. Consequently, the daily diet patterns suggested by nutrition committees in the Southern States take into consideration and build upon this commendable liking for "greens and pot likker."

Once weekly food lists for families of varying size and composition have been set up, welfare agencies have an invaluable tool for measuring allowances for food in family budgets. Since the publication of the allowances, many public and private welfare agencies have revised the food lists on which their budgets are based so as to conform to the new yardstick. These new food lists are then priced and the cost of an adequate diet for a given family is used as the standard to be met insofar as the resources of the agency permit. Workers who are struggling with revision of food budgets are making good use of the food lists that appeared in *Consumers' Guide* for October 15, 1941.¹

3. *"Vigorous and continued research"* into human nutritional needs and how they may be met unquestionably has been stimulated by the national nutrition program. A somewhat novel and encouraging feature of recent projects related to the nutritional problems of mothers and children is that they draw upon resources of various groups concerned with nutrition—physicians, biochemists, dentists, nurses, and nutritionists as well as laboratory technicians and statisticians. It was at the National Nutrition Conference that many heard for the first time of the recent Canadian studies on the relation of diet during pregnancy to the health of both mother and child. Widespread interest has been aroused in carrying on a comparable

¹For sale at 5 cents a copy by the Superintendent of Documents, Government Printing Office, Washington, D. C.

study in this country to confirm or challenge the Canadian findings.

Both physicians and nutritionists are working on the problem of low-cost foods for young children whose parents cannot possibly supply them with the conventional adequate diet. One pediatrician who observed how well children in a certain national group seem to thrive on a low-cost food that is not generally considered suitable for any but mature digestive tracts has been making some studies of the availability to young children of some of the minerals in this food. Before doubting Thomases make predictions as to the outcome of such a study they well may recollect how similar studies have changed the status of the banana from a *proscribed* to a *prescribed* food for infants.

4. "*More widespread education of . . . professional workers in the newer knowledge of nutrition*" is a major activity of many State nutrition committees and of the respective professional organizations represented on these committees. With the encouragement of the American Medical Association, State and county medical societies are featuring lectures on nutrition at their regular meetings and articles on nutrition in their journals. At the 1941 annual meeting of the American Public Health Association no less than six sessions were devoted wholly or primarily to human nutrition as a public-health problem. All the program sessions of the Maternal and Child Health Section were devoted to nutrition and all were held jointly with the Food and Nutrition Section. Other groups which participated in one or more of these joint sessions were the Health Officers Section, the Health Education Section, the Public Health Nursing Section, the American School Health Association, and the Oral Health Group.

Contrary to a prevalent impression, trained workers with a good foundation of nutrition and related sciences do not have to unlearn all their nutritional knowledge every 5 years or so. As Professor H. C. Sherman has reminded us, the newer knowledge of nutrition supplements but does not supplant the old. To keep abreast with this newer knowledge, professionally trained workers are enrolling in refresher

courses, which are sponsored by educational institutions, professional organizations, and State and local nutrition committees. A large group of enrollees in refresher courses is made up of professionally trained homemakers who wish to equip themselves to do their share in the defense effort. Many of them are getting ready to serve as instructors in the standard nutrition course offered by Red Cross chapters. This nutrition course, designed primarily for homemakers, gives due consideration to the nutritive needs of the children in the family. It seems reasonable to suppose that the "refreshed" teachers of these courses will apply their knowledge in their own homes as well as in the classroom.

5. "*Mobilization of every educational method and of all organizations and services to spread the newer knowledge of nutrition among laymen.*" Most people know instances of wider use of the radio, the press, and innumerable channels—commercial and otherwise—to spread the knowledge of nutrition. Among the most active groups represented at the nutrition conferences in a southern State were the ministers of Negro churches. Organized labor groups and their auxiliaries have sought and received suggestions from nutritionists on an educational program for their members. Individual food industries and associations of the food trades have joined forces for a campaign of public education.

Readers of *The Child* are likely to ask what they can do to make sure that children derive the greatest possible benefit from these manifold activities. They realize that all measures that are effective in raising the nutritional level of the people as a whole will contribute more to children than to adults because children respond more quickly to a change in their nutritional environment, whether for better or for worse. In general, therefore, they are well content that the national nutrition program should be all-inclusive in its scope. They do not minimize the importance of measures directed at the betterment of a part of the population, such as noon meals at school and factory meals for industrial workers. Such projects, realizing as they do the full potentialities for

nutritional betterment through a natural situation, are desirable in themselves. Moreover, experience in Great Britain during the war has shown how readily school-lunch programs have served as the nucleus for emergency feeding of whole families. It is important, however, to keep in mind that, in normal times, the furnishing of one adequate meal to the school child or industrial worker alleviates but does not solve even the individual's own food problem, much less that of the family of which he is a part.

Emphasis on the needs of the family should not of course preclude due consideration of the nutritional needs of children who are not cared for in their own families. There was never a time when so much help, along nutritional

lines, was readily available to those responsible for care of children outside their own homes. It is largely up to professional child-welfare workers and to board members to see that heads of child-caring institutions and foster mothers take full advantage of these greatly augmented community resources for technical consultation and instruction.

It would be foolhardy to predict how the entrance of the United States into the war will modify the nutrition program outlined by the conference. It can be said, however, that the possibility of war was never lost sight of during the sessions. In our sister democracy of Great Britain nutrition work has been greatly intensified as a part both of the war effort and of the plans for the post-war period.

BOOK NOTES

HANDBOOK OF COMMUNICABLE DISEASES, by Franklin H. Top. C. V. Mosby Co., St. Louis, 1941. 682 pp. \$7.50.

Those whose professional duties necessitate contact with communicable disease need a reference text in which medical, nursing, and public-health aspects of the various diseases are discussed. Dr. Top, director of the Division of Communicable Diseases and Epidemiology of the Herman Kiefer Hospital and Detroit Department of Health, has drawn upon the services of five doctors and two nurses, all in Detroit, to assist him in completing such a book. The first section consists of several chapters on the theoretical aspects of infectious disease. The second section is devoted to description of each of the common communicable diseases. Under each disease are discussed not only the medical aspects of diagnosis, treatment, prevention, but also the essentials of nursing care. Special points concerned with the epidemiology of each disease are brought out.

HIDDEN HUNGERS IN A LAND OF PLENTY. National Maternal and Child Health Council, 1710 Eye St. NW., Washington, 1941. 25 cents.

The National Maternal and Child Health Council has prepared in kit form a handbook of nutrition projects that may be undertaken by community groups who wish to take part in the national nutrition program. The American Association of University Women has cooperated in the enterprise; the American Red Cross

and the American Dietetic Association have given special assistance in matters pertaining to nutrition. Each of the eight sections in the handbook is built around a theme taken from the reports of the National Nutrition Conference for Defense. Each suggests specific projects that may be undertaken by a community and outlines readily available sources of information on the topics touched on in the section.

FOOD AND NUTRITION. Fourth edition. American National Red Cross, Washington, 1941. 87 pp. 25 cents.

This is the textbook used in the standard nutrition course of 20 lessons that is being offered by many local Red Cross chapters with the twofold purpose of equipping citizens to participate more effectively as consumers in the national nutrition program and of providing them with the necessary background for enrolling in the Red Cross canteen course. Both courses are taught by instructors authorized by the American Red Cross, and completion of each will be recognized by the award of a certificate.

THE ARMY'S TOOTHACHE; AN OLD STORY, by Paul E. Morgan. National Dental Hygiene Association, Washington, D. C.

On the thesis that the dental-health problem revealed through the examination of young men under the selective-service system has its basis in the dental health problems of children, the author presents a summary of the surveys made in Hagerstown, Md., from 1937 to 1941 by the United States Public Health Service.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

The I. L. O. Looks Forward

International cooperation looking toward better working conditions, higher living standards, and the protection of civil liberties was the keynote of the International Labor Conference that met in New York, October 27–November 6, 1941. This was the first International Labor Conference since the one held in Geneva in June 1939. So vital was considered this continuing thread of the movement for world organization represented by the League of Nations, that 35 of the 50 member countries participated, 33 through delegations and 2 through observers. As in previous sessions of the International Labor Conference, a full delegation comprised 2 Government delegates, 1 employers' delegate, 1 workers' delegate, and technical advisers. Twelve ministers of cabinet rank were among the Government delegates. The Secretary of Labor of the United States, Frances Perkins, was elected president of the Conference.

Much of the discussion related to the importance of and necessity for adequate post-

war planning on an international level. A resolution on post-war reconstruction put forward by Carter Goodrich, president of the governing body of the International Labor Organization, was adopted by the Conference. This resolution emphasized the need for advance planning and named essential points for international action in connection with reconstruction, including the feeding of people in need; reconstruction of devastated areas; supply and transportation of raw materials and capital equipment; restoration of economic activity; reopening of trade channels; settlement of dislocated workers and their families under conditions of freedom and security; change-over of industry from wartime to peacetime production; maintenance of employment; and general improvement in labor standards. It also called upon all member States to "set up representative agencies for the study of the social and economic needs of the post-war world."

BOOK NOTES

COTTON PLANTATION LABORERS; A SOCIO-ECONOMIC STUDY OF LABORERS ON COTTON PLANTATIONS IN CONCORDIA PARISH, LA., by S. Earl Grigsby and Harold Hoff-sommer. *Louisiana Bulletin*, No. 328 (February 1941), Louisiana State University and Agricultural and Mechanical College, Agricultural Experiment Stations. 40 pp.

This report analyzes the social and economic conditions of farm laborers in Concordia Parish, La., a typical cotton-growing section in the delta area of the Mississippi River. The report is based on information obtained from 27 plantation operators and 254 farm laborers who were interviewed in September 1936.

Of the farm laborers interviewed, 244 were Negroes, and these comprised more than one-half of the total Negro agricultural workers in the parish. Most of the data in the report relate to these Negro workers and their dependents.

There were 121 children under 15 years of age in the Negro households represented in the study. More than one-half of the children 10 to 14 years of age, inclusive, were found to be working, and also some children under 10 years of age.

The total average cash income of the Negro males in the study, taking into account relief payments and the earnings of dependents, was only \$178 for the year.

• *EVENTS OF CURRENT INTEREST* •

CONFERENCE CALENDAR

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|------------|--|-----------------|--|
| Jan. 27-30 | American Association of Schools of Social Work. Pittsburgh. | Apr. 6-10 | Association for Childhood Education. Golden jubilee, Buffalo, N. Y. Information from Association for Childhood Education, 1201 Sixteenth St. NW., Washington, D. C. |
| Jan. 30-31 | National Public Housing Conference, Pittsburgh. | Apr. 7-9 | Eighth annual conference on the Conservation of Marriage and Family Life, at the University of North Carolina and Duke University. Information: Professor Ernest R. Groves, University of North Carolina, Chapel Hill, N. C. |
| Feb. 4 | Sixth National Social Hygiene Day. Information and materials from American Social Hygiene Association, 1790 Broadway, New York. | Apr. 10-11 | American Academy of Political and Social Science, Philadelphia. |
| Feb. 4-7 | American Camping Association. Thirty-second anniversary convention, Minneapolis. | Apr. 27-May 1 | National League of Women Voters. Biennial conference, Chicago. |
| Feb. 8-15 | Negro History Week. Information and materials from Association for the Study of Negro Life and History, 1538 Ninth St. NW., Washington, D. C. | Apr. 30-May 1-2 | American Pediatric Society, Skytop, Pa. |
| Feb. 17-20 | Council of Guidance and Personnel Associations, San Francisco. | May 2-9 | Eighth Pan American Child Congress, Washington, D. C. |
| Feb. 18-20 | National Vocational Guidance Association, San Francisco. Information: N. V. G. A., 425 West One Hundred and Twenty-third Street, New York. | May 4-9 | National Congress of Parents and Teachers, San Antonio. |
| Feb. 19-21 | American Orthopsychiatric Association. Nineteenth annual meeting, Detroit. Chairman of Publicity Committee: Helen P. Langner, M. D., Vassar College, Poughkeepsie, N. Y. | May 5-8 | International Association of Public Employment Services, Louisville. |
| Feb. 21-26 | American Association of School Administrators, San Francisco. | May 6-8 | National Council of State and Local Welfare Administrators, New Orleans. |
| Apr. 6-10 | Second American Congress on Obstetrics and Gynecology, St. Louis, Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago. | May 6-9 | National Tuberculosis Association, Philadelphia. |
| | | May 10-16 | National Conference of Social Work, New Orleans. |
| | | May 10-16 | National Probation Association, New Orleans. |
| | | May 18-23 | Biennial Conference of Nursing Organizations, Chicago. (National Organization for Public Health Nursing, American Nurses' Association, and League for Nursing Education.) |

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

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The

CHILD

*** Monthly Bulletin ***

An Urban Experiment in Child Welfare

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The First Puerto Rican Child Congress

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The 1940 Record of Maternal and Infant Mortality

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Working and Living Conditions on Connecticut Tobacco Plantations

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

FEBRUARY 1942



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• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

An Urban Experiment in Child Welfare

As Carried Out in St. Paul, Minn.

By HAROLD B. HANSON, M. D.

Consultant in Psychiatry, St. Paul Project, U. S. Children's Bureau

BEHAVIOR problems in children are constantly challenging the interest and resourcefulness of all who come in contact with them. Teachers, parents, social workers, and even neighbors and others who meet children only casually are interested. Much study has been devoted to learning more about the best ways to train children and the most effective means of meeting behavior difficulties when they arise. In recent years knowledge in this field has steadily grown. Though there is still much to learn, it is now time to ask whether the most is being made of existing knowledge. Too often expert advice and treatment for behavior difficulties become available only when serious trouble has developed, when the parents are ready to give up, when the school can no longer tolerate the child, when danger to the rights of others forces the court to intervene.

What can be accomplished if adequate service is available to these children earlier? How can community resources be mobilized to find the children in need of such service before their problems become acute? With the rapidly increasing knowledge about children's needs, many specialized services to meet them have been developed, and children eligible for these services have profited greatly. However, many children have needs that are not being met by special services or needs that cut across many services. How can existing services be integrated to meet the needs of all children? What additional services are necessary?

The Children's Bureau in its Child Guidance Division is studying questions of this kind through a project located in St. Paul, Minn. A preliminary period to explore and determine the location of the unit and the type of unit needed preceded the establishment of the project, which has been organized for approximately 3 years as a treatment center for children with behavior problems. It offers psychiatric, psychological, case-work, and group-work services. A city neighborhood of limited size serves as a base for experimentation in treatment with the use of urban resources. During this period concepts of interest to general child-welfare programs, particularly those conducted under urban conditions, have developed. Although the work is far from complete, this report is offered because of interest which has been expressed in the work of the project up to this point by child-welfare workers and others who have come into contact with it.

Pattern of Approach.

As originally conceived, the St. Paul Project was organized for the "purpose of study, research, and demonstration of the methods and techniques that can be used effectively in prevention and treatment of delinquency."¹ Implied in this statement were not only the study and treatment of individual children with personality and behavior problems, including delinquency, but also a much broader program of

¹ St. Paul Project in the Prevention and Treatment of Juvenile Delinquency. *The Child*, December 1938, pp. 133-134.

studying the manner in which social and welfare facilities might be integrated and directed toward meeting the needs of all children and in this way be used to prevent many individual problems.

As no definite approaches to the answering of these questions were laid down at the beginning of the project, it has been possible to take advantage of new avenues of investigation as they have become available. This has allowed for free experimentation, which is needed in the field, but it has imposed some limitations on the degree to which the research and evaluation program could be set up with well-organized controls. It is the experience of the project, however, that this general exploration is necessary before carefully defined problems of research can be undertaken in special areas, and it is in this broader field that the project, up to the present time, has made its most marked progress.

Changes in staff members since the project's final organization have introduced artificial factors in its development. In spite of these factors—and such factors must be met in any long-time preventive program—a pattern of approach to the problem of prevention and treatment of behavior difficulties has been evolved, and it is within this pattern that the project is now operating. It should be emphasized that the specific problems encountered in child-welfare units will vary, but it is thought that the general pattern should be effective in any community.

The project was faced in the beginning with two broad objectives: the early identification and treatment of children presenting personality and behavior problems, including delinquency, and the development and integration of existing social and welfare facilities directed toward the needs of children. In carrying out these main objectives the project has experimented in the application of various types and combinations of services and the coordination of these services in one agency. It has also collected data on some of the aspects of child-welfare work that have wide interest. Services to children in their own homes, the interrelationship of social agencies and schools, a combined

case-work and group-work approach, the use of legal authority in treatment—these are some of the special areas that will be given consideration.

The two main objectives are not peculiar to the St. Paul Project but are, we believe, the basic aims of any program in child welfare, whether it be undertaken in an urban or a rural community. From the experience of the St. Paul Project it seems doubtful if there is any short cut to the attainment of these objectives, for although the pattern outlined may be followed by every community, each community will have its individual problems and lacks that must be taken into consideration. In an urban community with its many resources it may be mainly the effective utilization of existing facilities. In the rural area the lack of service may be most outstanding.

The first steps undertaken in such a program are the identification of children presenting problems and, through a study of their needs, an analysis of the requirements of all children in the community. The symptoms of maladjustment shown by children are generally known. Running away, social withdrawal, conflict with authority, and academic difficulties are a few examples. *Is it possible to learn of these symptoms before they become acute? What individuals or groups are in a position to recognize and report these early symptoms?*

In answering these questions the sources from which children are referred become an important consideration. They fall into two groups, which we may call primary sources and secondary sources. Primary sources are those groups which come in contact with the child in his daily routines and are able to observe him as he reacts to every-day situations—the schools, group-work agencies, and the home. Secondary sources are groups which are aware of the problem either through reports of others or through observation of the child in some specific instance, such as the police, the court, and health and case-work agencies. All sources are important for a complete understanding of children's problems, but the need of working closely with primary sources cannot be given too much emphasis, for it is these sources

which see the child in his daily adjustments and first become aware of significant problem behavior.

As children exhibiting problem behavior begin to be referred to the child-welfare unit, it is found that work must start with the cases that are causing the greatest concern to the community, and that the temptation to select only cases that have dramatic appeal or bring up problems of special professional interest must be resisted. The cases of immediate concern are not always the ones most hopeful for therapy and at first may not represent a cross section of children's problems, but before interest in the general needs of children can be aroused, immediate problems in the community must be treated. Illustrative of this in the St. Paul Project were the attendance cases referred by a school in the project area. At that time attendance was the problem of immediate concern to the school, and it was only by working on this problem that it was possible to show other ways in which the services of the project might be used.

Another aspect of the service program, which when put into words seems obvious but which under pressure of work is often neglected, is the need of working closely with sources of referral, keeping each source informed of developments in the case and, whenever possible, working out with it the role that it can play in therapy. Without this interchange of experience the child-welfare unit may well become one more agency occupied with its own program and only incidentally with children's problems as a whole.

The first process, then, is to establish relationships with sources of referral in the community, particularly primary sources, and, with the cases referred as a basis, to keep the source of referral in touch with the progress that is being made or the failure to make progress and the reasons for it. This constant interchange of information regarding the progress of the case is a key point in the development of a satisfactory program, and it is only through this that the next step of generalizing from the particular can be taken.

As individual cases are accumulated from various sources and the needed treatment is outlined and undertaken, the general needs of the children in the community begin to emerge. In the St. Paul Project the need for remedial instruction became apparent as cases mounted up where the behavior pattern appeared in a child of average ability unable to progress in school because of a specialized disability. A need for more adequate facilities for group activity has also become apparent from the many cases in which the problem behavior was of a mischievous type because of the fact that the child had had no opportunity or direction in finding satisfactory outlets. In another community these needs might not assume importance but be seen only in isolated instances, and problems resulting from the unsatisfactory fulfillment of other needs might assume greater importance.

As the resources of the community are called upon to meet these needs, the strengths and weaknesses of the social-welfare facilities become apparent. In some instances there is a definite lack of service in the community. In others there is merely the need for a closer coordination of existing services. The way in which the need is met depends upon the social, economic, and welfare structure of the community, but it must be met by the community. The work of the Council To Coordinate Schools and Social Agencies in St. Paul is an example of one of the ways in which a community is studying its problems and planning for their solution.²

The pattern, then, whether it is to be followed by a child-welfare worker in a rural community or by a treatment staff in an urban area, stresses a plasticity of approach which takes advantage of the assets of the community and studies ways to overcome any inadequacies that may exist. The fundamental steps are: (1) To come in direct contact with children needing service; (2) through helping to solve the problems of these children, to gather data on the needs of all the children in the community; (3) through constant interchange of information with referral sources, to

² See section on child-welfare service and the schools.

bring about in the community an awareness of these needs and study by the community of ways of organizing present resources and developing additional facilities for meeting them. This is presented not as a new procedure or a new pattern but as a basic principle, which is often lost from sight as new treatment techniques are investigated or special services capture the imagination.

Project Setting.

A city of medium size³ was chosen for the location of the Children's Bureau project, so that conditions would not vary too widely from those of the average urban community. Factors influential in the selection of St. Paul, Minn., were that its child-welfare services had been organized on a public basis for a period of approximately 20 years, the emphasis of social agencies was toward community-mindedness rather than agency-mindedness, the judge of the juvenile court and the probation staff were interested in having an experimental project organized in the field of juvenile delinquency, and the services of the public relief agency were apparently more nearly adequate than those of many other cities.

Within St. Paul a limited but representative section of the city was selected to allow ready access to children in their daily environment. The area covers one and a half square miles and extends from a central business district to a predominantly residential section. It has some natural boundaries, which coincide with those of three primary public-school districts but which do not tend to set it off in its social life from surrounding sections of the city.

The population of the area is approximately 20,000 persons. Of these, about 7,000, or 35 percent, are youth of 21 years or younger. The nationalities, the racial and religious backgrounds of the residents, and other social factors, such as the number of families receiving relief, the incidence of juvenile delinquency, the quality of housing, and the existence of public and private recreational facilities indicate that the area is representative of fairly average conditions of urban life. Approximately 50 percent of the population is of German extraction. Other nationalities or racial groups are Hungarian, Polish, Scandinavian, Irish, and Jewish.

There are three public primary schools in the area and four parochial schools, of which three are Catholic and one is Protestant. All of the Catholic pa-

rochial schools draw children from a wider area than the project district. One is definitely a Polish school and draws from many parts of the city. The largest is a school attended in the main by children from families of German background. At the beginning of the project this school included ninth and tenth grades, but with the completion of a new building it now includes all high-school grades. The third Catholic parochial school does not have a very distinct racial character. One public high school and a boys' vocational high school are immediately adjacent to the area.

Three Catholic churches, serving areas corresponding to the parochial-school areas, four Lutheran churches, and three small churches of other Protestant denominations are located in the area.

Group and recreational activities at the beginning of the project were varied, but, as in many communities, funds were not available to provide enough leadership or equipment to meet children's needs adequately. There were two city playgrounds but no community center or neighborhood house. A Work Projects Administration recreation program was being carried on in one of the public schools, and a few Girl Reserve, Campfire Girl, and Boy Scout groups were meeting in schools and churches. Other scattered civic and recreational groups existed, including two playground-booster clubs, several parent-teacher associations, and a business men's club. The social life of the area was organized around the various racial and religious groupings with little development of community interest in neighborhood problems.

To overcome some of these limitations and to arouse a more general neighborhood consciousness, some changes in the recreational and social organization of the area have been brought about. Under the leadership of the project group worker, group-work programs have been centered in three school buildings, two public and one parochial. Activities have been varied and have included athletics, gymnastics, dancing, singing, Girl Reserve clubs, troops of Campfire Girls, gang groups, and social clubs. They have been adapted to a wide age range with groups for little tots and groups for adults. A summer camping program has also been developed with a day camp program for younger children and period camp placements for the older ones.

³ St. Paul has a population of 287,736 (1940 census).

Leaders have been recruited from the Work Projects Administration, National Youth Administration, the Graduate School of Social Work of the University of Minnesota, and local colleges. The Graduate School of Social Work of the University of Minnesota has assigned students in group work to the project for their field experience, and the local colleges have recommended volunteer student leaders.

As a result of these activities a neighborhood recreation committee is now active in facilitating the placement of neighborhood children in camp and in planning for the neighborhood group-work program. Agencies and service clubs active in the area have helped to meet the expense involved. Therefore the neighborhood at the present time shows a greater interest in community problems, and a sounder basis exists for experimentation in treatment with the use of community resources.

The headquarters of the project are located on a main thoroughfare at one edge of the area at about the midpoint. The offices are on the second floor of a business block. They include one large room which is suitable for staff or committee meetings but no space suitable for group-work activities, social gatherings, or community meetings of any size.

The staff as finally organized includes the following members: A psychiatrist who is the local director of the project; a psychologist who is responsible for the psychological service and program of evaluation; two case workers; and a group worker. The visiting teacher provided by the Amherst H. Wilder Charities acts for the project as a case worker with the schools and also carries the responsibility of demonstrating visiting-teacher services in St. Paul. In addition to these services, office space is provided for a station of the St. Paul Family Nursing Service, where weekly prenatal and child-health clinics are held.

The advantages of assembling members of different professions in one unit have been apparent from the beginning. It has made it possible to study in detail the problems of the closer coordination of the services represented. This information should prove of value in bringing about a more effective use of services

not only within one agency but also in separate agencies. Each profession represented brings to children's problems not only the knowledge common to all groups dealing with children but also philosophies and techniques developed within that profession. The points of conflict in the practical application of these many techniques can be solved only by joint study of the problems. The St. Paul project, therefore, is able to serve as a laboratory for the clarification and solution of some of the difficulties presented.

A unit of many services also has definite advantages to the client. A person cannot be expected to see the serious implications of what to him is a minor problem. So when it is necessary to refer him from one organization to another, he often becomes confused or discouraged and decides to wait, hoping that the problem will solve itself or at least not become more acute. If, however, after making one contact it is possible to receive the necessary service without additional effort, a satisfactory relationship may be more readily established and the development of serious problems prevented. The initial referral also tends to be made at an earlier stage in the problem's development because the possibility of coming to one agency with any problem eliminates the necessity for the client to assume the responsibility of deciding which of many services he needs; his only responsibility is to make the decision that he needs help with his problems.

Plan of Study.

As the main trend of the project has been developed, attention has also been given to some of the specific problems that confront child-welfare workers, and data are being collected to throw light on these problems and point the way for further research. The collection of such data, as well as the study of the main trends of the project, indicates the need for evaluative procedures.

The nature of the project made it necessary to set up an evaluation program, not to prove or disprove a given hypothesis but to start at an earlier stage in research, that of collecting data from which some hypotheses may be formulated. With this as the core of the program,

material has been assembled in such a manner that the project as a whole or any phase or technique of the project may be quickly reviewed. Thus it is possible to study trends and discover areas where greater emphasis should be placed, and, with the data assembled in final form it may be possible to formulate working hypotheses of value to the child-welfare field. For this purpose, various schedules for recording and evaluating the data have been developed. Some continue to be used in their original forms; others have been under constant revision as the periodic reviews have shown weakness in their structure. This has, of course, been a time-consuming part of the project's work, but it has value in that it helps to define the principles fundamental to a sound child-welfare program.

At the present time three schedules are in use in addition to the case records and descriptive material relating to interviews and community contacts:

The service card is, as its name suggests, set up to keep an accurate record of all services, case work and group work, rendered to individuals by the project. From the data on this card it is possible to make analyses of: (1) The amount, duration, and type of service rendered; (2) sources of referral and reasons for referral; (3) underlying problems revealed by study; and (4) services of agencies most frequently used by the project in the diagnosis and treatment of cases.

The second schedule, *the delinquency card*, is designed to show the amount, extent, and kind of delinquency in the project area that comes to the attention of the juvenile division of the police and of the juvenile court. It is so organized that it is possible to study the cumulative record of delinquency for any one individual and also the individual in relation to his associates in delinquency as well as the continuity within these delinquent groups.

The case-study schedule is the third instrument for evaluation and is designed to aid in the analysis of case material and in the evaluation of the efficacy of the treatment given. This schedule, as now used, consists of four sections: The first, for rating problem behavior; the second, for recording factors that may contribute to the problem behavior; the third, for recording treatment; and the fourth, for making a diagnostic summary.

A few of the phases which are receiving special attention and in which the problems are most clearly defined at this time are presented in the following sections. Investigation in other

phases is also under way and will be reported upon in later publications.

Aspects for Special Study.

1. *Intensity and type of treatment.*—Exceedingly important contributions have been and are being made by child-guidance clinics, but it is becoming evident that, from a practical point of view, these highly specialized facilities cannot be made available to every child presenting a problem; and the experience of clinics has shown that but a minor part of the cases referred to them need or are accessible to the most intensive types of therapy. *What are some of the treatment techniques to be used with this larger remaining group of children? How intensive must the work be if it is to be effective? Is there a relationship between the problem presented and the type and intensity of treatment needed?*

With these questions in mind, the project is recording and evaluating the service and treatment, no matter how slight, given to each child. Although the material collected will demand careful study and interpretation, preliminary surveys indicate that there has been a wide range in both type and intensity of treatment offered. Follow-up will, of course, be necessary before coming to conclusions as to efficacy; but when this is done, we anticipate that some of the answers to the questions relating to types and intensity of treatment and service will be available and that the direction for further research in this field will be apparent.

In appraising the intensity of treatment it will be possible to make two types of analyses. The first is intensity or depth of treatment as it relates to any given service. In some instances it has been thought that the child's need could best be met by working intensively with him through one service or a combination of services as, for example, the emotionally disturbed child who needs intensive psychiatric treatment. The cases which are most effectively treated in this manner fall into the group which needs the skills of highly trained workers with case loads limited so that time adequate to the child's needs can be reserved.

The second type of analysis is intensity as it relates to the number of services that are

called upon in the treatment plan. This group may include some children of the first type, but it also includes the child who, although needing some help in one or many areas represented, can be treated effectively by a joint approach without individual therapy of an intensive nature or time-consuming supervision of any one worker. For example, the child whose maladjustment is due to an unsatisfactory school placement complicated by limited recreational resources and failure of his family to understand his basic difficulty may require all types of services offered, but when a plan of treatment has been outlined he may respond satisfactorily with no more than occasional contacts to insure that the situation remains improved.

A study of the depth and spread of treatment will answer some questions, but the nature of the treatment also is important. Besides the types of treatment implied in the services offered, therapy can be described as being supportive. This implies that the relationship developed with the child is used primarily for the purpose of giving encouragement and reassurance. It may be the manipulative type, in which the essential component is the direction of treatment toward the modification and enrichment of the child's environment. Interpretative therapy is directed toward developing in the child treated a better understanding of persons and conditions outside himself as they relate to his problem situation; and insight therapy centers around a relationship used to assist the child to a recognition of his problems in terms of his desires and frustrations as they interact with his environment. In this latter type of analysis interest lies in the qualitative rather than the quantitative aspects of treatment. Although a three-way analysis of treatment is being undertaken, the project is keeping in mind that these three approaches are not mutually exclusive.

A detailed description of the services offered and their application to the treatment program of the project will be made when the effectiveness of the treatment program as a whole is assessed, but a brief discussion of the tutoring program, which is under the supervision of the psychologist, seems pertinent at this time so

that treatment resources can be fully understood.

Any program concerned with the treatment of children's problems must cope with the child who is having difficulty in the academic field; for the school situation, to the child, is the equivalent of the job situation to the adult; and unless satisfaction can be obtained in this area, problems may appear in all phases of his life. To treat these children whose academic problem is contributing to their maladjustment the project has turned first to the schools for help. In many instances the concerted approach by both agency and school has resulted in a more satisfactory educational program for the child and improvement in his behavior as a whole. The schools, however, do not always have the resources necessary for the individualized treatment that is indicated, and it is to meet the need of the children for whom there are no available facilities that the project's tutoring program is aimed.

The program has centered around the children with specific disabilities in the field of reading, although children with difficulties in other subjects have been included when necessary. Graduate students in the field of remedial reading at the University of Minnesota have served as tutors with a few volunteers who have had an adequate background for the work.

That such facilities must be available in a community if a large number of children with problems are not to go unaided will be brought out, it is believed, by the data that the project is gathering relative to intensity and type of treatment. The evidence for this will be based on the study of children who not only have been educational problems but also have shown signs of maladjustment in their social relationships. Whether this maladjustment has resulted from failure in school or the school failure has resulted from the maladjustment, it has been apparent that unless treatment could attack the academic problem, it could not hope to be successful. The necessity for close cooperation between the schools and child-welfare services meeting this area of need has become increasingly evident.

2. *Case work and group work.*—Within the combinations of services used in treatment is that of case work and group work. Because close coordination of these services, particularly within one agency, is a comparatively new development in social work and has not reached the degree of uniformity that the psychiatric, psychological, and case-work combination has achieved, the project is giving special attention to experimentation in this field. With the group-work program that has been developed in the area as a basis, the project is approaching the coordination of group work and case work.

In discussing the pattern of approach, we placed group-work agencies with the primary sources of referral, that is, with the sources which see the children in their every-day activities. The group worker sees on the playground and in club activities many children who are having difficulty making satisfactory social adjustments. In some instances the child is the center of much of the friction that arises on the playground; in other instances he is not accepted by the group and is being forced into solitary activity. To the group worker the problem seems deeper than a temporary disturbance in group adjustment and appears to arise from a basic personality pattern. A conference is, therefore, arranged with a case worker, and a plan is formulated which gives the case worker opportunity to become acquainted with the child, study his problems, and help him arrive at a solution for them. Through frequent conferences between the case worker and the group worker a joint understanding of the child and his problem is developed, with the result that the child, by discussing his individual problems with the case worker, gains insight into the reasons for his maladjustment in the group and, with the aid of the group worker, is able to test his new-found insight in suitable group situations. These may have to be protected groups at first, but as the child becomes better able to deal with group situations, he can be given wider scope for his new-found abilities.

The second approach is the converse of the first. The case worker, as he works with a

child who may have been referred for some problem not directly associated with group activity, finds that the child has limited recreational opportunities. Consultation with the group worker leads to the selection of a suitable group for the child, the group worker helping him make the preliminary contacts. Or again it may appear after consultation with the group worker that the child is not sufficiently well adjusted to find participation in an unprotected group a satisfactory experience, and a protected group under the direct supervision of the project is used as a means of aiding the child in his group adjustment.

In such a program the selection of a suitable group is fundamental to successful treatment, and the project has called freely on the group-work resources in the community to meet the needs of individual children. It has been found that for many children the organizational pattern of programs such as the Boy Scouts, Young Men's Christian Association, Young Women's Christian Association, and Campfire Girls, with planned objectives and systems of awards, provide the necessary stimulus for increased social development; for others the less closely organized social clubs of school or church centers prove more satisfactory. The case worker and group worker discuss the needs of the child, consider the established programs in the community as they relate to these needs, and select the program that seems best suited to the child. The nature of the program is explained to the child, and careful arrangements are made for his preliminary contacts with the group; for much of the success of treatment depends upon the child's early experience in the group situation.

The discriminating use of established community programs is proving an effective therapeutic aid by developing in the child social skills and with them increased social acceptability. These programs, however, have been established to meet the customary needs of children and are not designed for the child whose pattern of behavior ranges far from the norm. *Can a combined case-work and group-work approach be used effectively with some of these more seriously maladjusted chil-*

dren who are so threatened by group relationships that participation in the more usual group programs serves only to accentuate and increase their problems?

Increasing recognition is being given to the fact that many children need experience in a controlled group situation before they can successfully cope with the give and take of normal social contacts. Group therapy with children whose maladjustment is so severe that it is incapacitating has already met with some success. It seems probable, however, that group therapy with these children, whose maladjustment is extreme in many respects, will, like their individual treatment, always remain a highly specialized technique available in certain adequately equipped centers but, from a practical point of view, impossible to operate in every community.

However, between the essentially normal and the definitely disturbed child are a large number of children who, while far from being incapacitated, are still handicapped to such a degree that the average group experience serves as a definite threat. It is for this group of children that the protected groups of the St. Paul project have been organized. These groups are small clubs which children with some problem that is definitely handicapping in their social contacts are invited to join. The members are carefully selected so that the interplay of problems can be handled to the advantage of all. The leader of these groups is well acquainted with each member's problem and with this knowledge controls the pressures placed upon him in accordance with his ability to withstand them. Both the case worker and the group worker take an active part in the group's formation. Preliminary conferences result in a well-formulated plan of the role to be played by each worker in the treatment of each child's problems, and the continued interchange of information leads to the effective interplay of individualized and group techniques.

A wide range of group-work activities, such as swimming instruction, model airplane building, educational trips, hikes, dramatics, athletics, and singing, is utilized. Activities

are chosen for their potential therapeutic value for all members of the group. The choice may be made with reference to the abilities of one or more members of the group, in order to develop in them the feeling of competency that the possession of a special skill or knowledge should give. Participation will benefit others by giving them the experience of actually attaining proficiency that will enhance their social prestige. For others it will serve as a means of helping them subordinate their own interests to the general interests of the group.

It is these problems, then, that the St. Paul project has selected as carrying the greatest significance in the study of the closer coordination of case-work and group-work services: (1) The problem of referral from one service to another, with the study of the contributions that can be made by each; (2) the effective use of established group programs in the treatment of children with problems; and (3) the use of the protected group in a therapeutic program and its practical implications to any community with case-work and group-work facilities.

3. The child-welfare agency and problems of delinquency.—One of the major considerations leading to the establishment of the project was the need for further light on the question of the potentialities of public child-welfare agencies in dealing with delinquent children. The opening of the project came at a time when there was much discussion of the function of the juvenile court in dealing with problems of delinquency and neglect and of the wisest division of responsibility between the juvenile court and child-welfare agencies. It was obvious that court and probation workers were often hampered in the establishment of therapeutic relationships by the connotation of compulsion, threat of punishment, and social stigma with which the court was still identified in the public mind. There was also the question of the effect of court procedure upon some of the delinquents brought before it. In some instances, for example, the experience was so traumatic that the result was destructive rather than constructive; antisocial attitudes were increased rather than modified. In other instances, the

effect was that of actually encouraging further misconduct by unwittingly adding to the child's prestige among his delinquent associates. For some individuals, on the other hand, it was equally certain that the legal formality and impersonal authority of the court were indispensable as part of a constructive treatment plan. In certain cases the resort to court action was a necessity when community resources in treatment had been exhausted and when the protection of the community could be served only by commitment of the delinquent to an institution. Recognition was being given to the fact that the court was overloaded with responsibilities and in many communities had, in fact, become another social agency with so many types of problems referred to it that its judicial function was in danger of being obscured. Many cases requiring no judicial action were being handled by probation departments. It seemed possible that some of these cases could be handled more effectively in a child-welfare-agency setting, if adequate facilities were available.⁴

At the same time a great impetus had been given to the development of public child-welfare programs, particularly in rural areas, by the availability to States of social-security funds through the child-welfare services. Many questions were arising relating to the ways in which such programs could best be organized, the fields of service they should attempt to cover, and the manner of their functioning in relation to other organized forces for child care and protection in their communities. Planning was being done on a State-wide basis, and this was affecting urban as well as rural areas. Clearly, it was an opportune time for the assessment of the possibilities and values of shifting some responsibilities from the over-worked courts and probation departments to the more general type of child-welfare agency and for the study of the most advantageous ways in which the two types of agencies might cooperate in their work.

With a view to such studies the project has accepted cases of children already involved in

delinquencies as well as children whose behavior difficulties were at an earlier stage and has made no differentiation in the general lines of treatment followed for the two groups. Underlying this experiment is acceptance of the philosophy which minimizes the difference between the delinquent child and other children, which considers that delinquency is merely a category under which are classified some of the symptoms manifested by children when they are unhappy or underprivileged or subjected to warping or destructive influence.

The project has taken the initiative in working out plans for referral or for cooperative work on cases with the juvenile division of the police department and with the juvenile court and probation office. The juvenile division of the police department has proved to be the source of referral of most of the cases of delinquents coming to the project. This is naturally the case, as the police usually come in contact with a child before he is sent to court and are in a position to make a choice between referral to court and referral to a child-welfare agency. This is also the more favorable point at which to secure a referral, as it tends to reach the child early in the growth of his behavior difficulties when his experience with other treatment methods is at a minimum.

To facilitate referrals, weekly visits are made to police headquarters by one of the project's case workers to talk over cases of children who have come to the attention of the police during the week. Gradually, the number of referrals to the juvenile court of children living in the area has decreased. The number of children coming to the attention of the police has also decreased. The latter decrease may be related to the fact that the project has concentrated on getting referrals from primary sources, such as the schools and group-work sources, thus reaching many problem children before they have come into conflict with the law.

The problem of making the initial contacts on the cases referred by the police is one which child-welfare agencies frequently have to face. The difficulty lies in minimizing the aspect of compulsion involved in any referral made by

⁴Nutt, Alice Scott: *The Future of the Juvenile Court as a Case Work Agency*. *The Child*, July 1939, pp. 17-22.

the police and in gaining acceptance from the child and his family on the basis of their understanding of and desire for the agency's services and not on the basis of fear of the consequences, should these services be refused. The project finds that it is more satisfactory, in most cases, for the project worker to introduce himself than for the police to take the responsibility for referring the child to the project office or for telling him that the project worker will call. The mere fact that the introduction comes from the police implies the obligation to accept the service. In a group of cases in which referrals came from both the police and schools, the school referral was used with the family as the reason for entry. It will be interesting to compare the success in establishing treatment relationships in these cases with the success in those cases where the police referral was used.

In treatment of delinquent children, as of any other children showing behavior difficulties, the use of authoritative measures alone, with their implied threat of punishment, is a negative form of approach. A positive approach involves an attempt to understand what basic factors are contributing to the development of the problem and to formulate a program designed to affect constructively the child's experience, emotions, and thinking. Such a program may need to involve the use of authority and punishment, but this will be planned with a view to its constructive effect on the whole child. The goal is the growth in the individual of the power of socialized self direction. This is well understood by progressive courts and probation departments throughout the country, many of which have been working on just such programs. However, the fact that the court setting is basically an authoritative one means that the temptation to use that authority in treatment is ever present. Also, constant pressures from the community to obtain results by repressive measures are present; more serious still, the child and his family frequently expect and fear that such measures will be used. The child-welfare agency is more free, psychologically if not actually, to choose its methods of treatment, for less pressure is placed

upon the therapist to assume an authoritative role. The project's position in the community has been even less authoritarian than that of the usual public child-welfare agency. With a reasonable degree of success it has also avoided becoming known as an agency dealing primarily with delinquents. It has taken advantage of this freedom to choose its treatment methods by putting the emphasis upon the use of nonauthoritative methods with children exhibiting behavior problems, whether or not the children are technically delinquents.

This does not mean that appeals to authority have not been made when clearly needed, whether to provide protection, to give support when the individual is not strong enough to function adequately without the backing of authority, or to supply the individual with needed punishment to relieve him of guilt. Recognition is given to the fact that the exercise of actual legal authority is not necessary to give treatment an authoritative quality. The suggestion of appeal to authority or the use of the relation of the therapist to the child for authoritative purposes may produce very similar effects. These and other ways of injecting an authoritative quality into treatment have been taken into consideration in defining authoritative types of treatment for purposes of analysis.

Studies of the points at which it became necessary to use various types of authority as well as studies of cases of delinquent children in which solutions were reached without appeal to authority are expected to be of interest in relation to the question of the use of the court in dealing with delinquent children.

4. *Child-welfare activities and the schools.*—The importance of emphasizing a close co-operative relationship between social agencies and schools has already been stressed in child-welfare programs, for the school holds a key position in the community as a referral source and also has much to contribute to the treatment program.⁵ Its value as one of the primary sources for referral of child-welfare prob-

⁵ Abbott, Grace: The Juvenile Court and a Community Program for Treating and Preventing Delinquency. *Social Service Review*, June 1936, pp. 227-242.

lems is readily recognized. Since most children of school age must attend school, the school staff has an excellent opportunity to become aware of children presenting difficulties before they become serious problems. A close working relationship with welfare agencies not only will facilitate referrals from the school at this early point but will also permit the social workers to call to the attention of the schools the educational needs of children known to the social worker.

In the treatment program, also, a close working relationship with the schools is important if the teacher and the child-welfare worker are to coordinate their activities in behalf of the child. The child-welfare worker should not underestimate the importance of the teacher's role in developing a satisfactory educational program for the child and in supplying direct encouragement in her daily contacts with him. Furthermore, the school provides a natural approach to the child and the family through a channel that is acceptable to them, although the actual referral may have come from the police or a relief agency. This approach is also valuable in situations where emphasis upon the specific situation that brings the child to the worker's attention may be ill-advised in that it places more weight upon the symptom than upon the basic problem. Careful study is being made of this indirect approach to problems referred from secondary sources.

Because of this need for more definite information relating to ways in which closer working relationships between social agencies and schools can be developed, the project, as an experimental child-welfare unit, has taken an active part in studying and developing this field, first in the project area, and later in the city as a whole. Work began in the project area with the problems of individual children. On one side were the cases referred to the project by the schools for study, on the other, the cases which the project wished to bring to the attention of the schools for their special services. As both types of cases were discussed in conference by project workers, principals, and teachers, the general problems relating to the function of the case worker and the school in helping the child toward a satisfactory adjustment were clarified

and procedures for the better coordination of these functions developed. General areas discussed included the values to the school from the case-work study of the child in all the complex relationships of his life; the use of the case worker in interpreting to the child some of the reasons for his behavior; the need that maladjusted children may have for individualized school programs, particularly in the early stages of treatment; and the conflict between individualized treatment and the school's need to demand a certain degree of conformity to routines and regulations if it is to perform its function in the field of education.

Other points more specific in nature but necessary for satisfactory cooperation included times to interview teachers that would not interfere with class-room routines and the arrangement for contacts with the child himself at hours when he could be absent without losing basic instruction. The need for constant interchange of experience and information stood out as particularly important in developing close cooperative relationships between the child-welfare unit and the schools. As the schools saw the strengths and limitations of the project services and as the project became aware of the assets and liabilities in the school program, it was possible for both the agency and the school to become much more effective in both referrals and treatment.

As the work of the project developed, the advantages to be gained from a close cooperative relationship between social agencies and schools spread rapidly throughout the city. That a gap existed between these two fields had long been recognized by a number of persons in St. Paul, and this initial recognition of needs together with the widespread interest in agency-school relationships provided an opportunity for the project to suggest to a group representative of both fields that officials of the welfare council and the superintendents of public and parochial schools appoint a joint committee to explore means for effecting cooperation on a city-wide scale. In response to this request, a committee composed of representatives of the public and private social agencies, the group-work field, the police and juvenile court, and the pub-

lic and parochial schools was appointed under the auspices of the welfare council.

With the formation of this committee, known as the Council To Coordinate Schools and Social Agencies, in the spring of 1939 the third step in the project's pattern was taken. The community itself assumed responsibility for studying ways in which the social agencies and schools could coordinate their services to meet better the needs of all children.

From this point the work spread beyond the limits of the project area, reaching all schools and all districts of the social-welfare agencies. The project, however, as a child-welfare unit in the city, has continued to participate actively in a leadership and advisory capacity. Its experience in this field on an area basis and the part it played in the formation of the council made it logical for the community to look to the project for advice and leadership. The project's psychiatrist has served on the steering committee of the council and, more recently, as chairman of the group; and the visiting teacher with the project has been assigned by the Amherst H. Wilder Charities to spend part of her time in developing the work of the council. In this way the experience and techniques developed in the project area were incorporated into the broader study, and the project has been able to follow closely the community's growing awareness of the needs of all children and the development of agency resources to meet these needs in a community that has no established program for social work in the schools.

The work of the council and the results achieved by it have proved to be unique in the study of agency-school relationships.

Important among the problems considered because of their general significance to child-welfare workers, is that of referral. It early became apparent that in many instances both agencies and schools were working in the same family with no knowledge of each other's activities. The problem of the child had not become acute enough to attract the agency's attention, and the school, unaware that an agency knew the family, was attempting to solve the child's problem without a complete picture of the situation.

The development of an adequate method of clearing cases brought out many major difficulties. Among them was the question of interchange of information. *Is it a sound practice for an agency to request information without giving any in return? Is it not as possible to exchange pertinent information with the schools without violating confidences as to exchange it with other agencies? Without this information can the school be expected to handle the child wisely in its daily contacts with him? What types of information should be exchanged as a matter of routine between agencies and schools?*

Problems arose as to the adequacy of agency services for children, in type as well as quantity. What steps should be taken to meet the needs of the child and family who are unable to take the initiative in contacting the agency? Among these individuals are the children who are daily withdrawing from reality, as the teacher can see, but who need skilled treatment before they can be expected to take the responsibility of keeping appointments. What is the community's responsibility to these children? Are agencies that base their intake policies on requests for help able to meet this responsibility? Can adequate child-welfare service be given without an agency in the community whose workers are trained to make contact with and treat the child at home or at school and help him to work out his problems before community pressure demands authoritative action? This latter question is one which has held particular interest for the project because of the work and experience in this field. It appears to be a field that has wide implications for the child-welfare worker and one in which there is much to be learned about methods and techniques in making such contacts.

The discussion of these problems as well as others studied by the Council To Coordinate Schools and Social Agencies and the attempts made to coordinate existing services have developed a greater understanding of the needs of all children and a recognition of some of the inadequacies in the social-welfare structure for meeting them. It is apparent now that this instrument, created to meet the specific prob-

lem of lack of coordination between the social agencies and the schools, has raised questions of much broader significance and will be an important factor in bringing about community effort toward a more general child-welfare goal.

5. *Social services for children.*—Community interest in the immediate contributions of the project to the development of needed services in the community is equal to, if not greater than, interest in the collection of experimental data upon which more general findings may be based. Conversely, the project's ability to make some immediate contributions may be a partial test of its practical value. The project in St. Paul has served as a laboratory in which types of child-welfare services not generally available in the community have been tried out, their usefulness assessed, and their implications in terms of the whole community social-work structure explored. In the course of these activities the project has been able to participate in a major community development of great importance, a movement toward securing a basic general child-welfare program for services to children in their own homes.

Such a program has been lacking in St. Paul, as it has been in a great number of cities. This may seem surprising in view of the fact that interest in public services for children developed early in Minnesota. However, these early developments were chiefly along specialized lines, such as the development of foster-home programs, and the provision for care of feeble-minded children and children of illegitimate birth. The more recent developments in public welfare in St. Paul, as in most other cities, have been in the area of general relief and along the lines of specific categories of the Social Security Act.

Awareness of a need for services for children in their own homes has been stimulated by pressure coming from a number of directions. Outstanding was the work of a committee of the welfare cabinet of the St. Paul Welfare Council, representing children's and family agencies, public and private, which was appointed to study the problem of neglected children and the available social-work services

for dealing with it. This study, which began early in 1936, was in progress at the time the project opened and continued on an intensive basis for more than 2 years. Members of the project staff worked with the committee during the latter part of the period.

Questions had been raised about the adequacy of protective work for children in St. Paul, as there was no specialized agency giving service in that field. The study, which revolved chiefly around the handling of incidents of acute neglect, many of which demanded court action, revealed also that no agency had as a primary function the servicing of neglect cases in their earlier and less serious stages when skilled case-work services might offer more promise of a satisfactory adjustment without removal of the children from the home.

The concluding recommendations of the committee were against the creation of a new agency to undertake protective work for children. Legally, the responsibility for dealing with problems of child neglect rested with the county welfare board. It was recommended that the county welfare board assume this basic responsibility and that it create a specialized program within its public assistance division for the treatment of neglected children. The county welfare board recognized its responsibility and agreed to assume it but did not provide for a specialized program. Although this increased the recognition of the problem it left the community with little progress toward solving it.

The project has not undertaken cases referred for acute neglect at a stage when court action was indicated, as this responsibility was definitely accepted by the county welfare board. Instead, in its own area, it has offered a service not generally available elsewhere in the city to a group of cases involving neglect in which work with the parents toward improving the situation seemed hopeful. This policy has harmonized with the general philosophy of the project; for the potential neglect case, like the potential delinquency case, lends itself to non-authoritative treatment. Also, the early neglect case is often an early delinquency case; for the inadequate home is one in which the

incentive toward delinquency is great and in which the controls to prevent it are weak.

The referrals for this type of situation have come from all avenues. However, primary sources again are very important, not so much because they more readily pick up evidences of neglect as because they are in a position to detect early the behavior difficulties arising from the neglect situation. It has been found repeatedly that children referred because of behavior deviations belonged to families already known to other agencies as families in which neglect was present. Sometimes the agency was aware of the behavior problem. Frequently it was not. Often the home was more accessible to treatment on the basis of the child's problem than it had been through a direct attack on the lack of parental care. The project's contribution in the area of child neglect has been in terms of treating neglect cases not as a specialized group but as part of a general child-welfare program. Usually the approach has been through the child's problem, and instances of successful treatment can be shown even in fairly acute situations which had earlier failed to respond to more coercive types of treatment. This has been true not only in cases handled directly by the project staff but also in cases which were handled cooperatively with other agencies or in which the project offered the other agency consultation service only.

Another set of pressures for more adequate case work with children in their own homes has come out of the work of the Council To Co-ordinate Schools and Social Agencies. Attention was focused again upon the extremely limited service available through any agency in the community for this specific field. Again the thinking has been in the direction of centering the responsibility in family agencies. With this pressure some movement has been made in private family agencies to realign their work in order to give more services to cases referred by the schools. However, only a fraction of the need can be met by these relatively small agencies. A large number of cases in which the schools have requested services for children are already under the care of the

county welfare board, and, as the basic public agency, it is again being asked to give services for which it has little preparation.

This situation has made visible an area of need which was hitherto little realized and for which service resources are inadequate. It is an area of need which the project has been serving from its inception, as a result of its early emphasis on seeking referrals from sources close to the child's own life. In the project area, even before city-wide consciousness of the problem had been aroused, the project had been working alone or cooperatively with other agencies on behalf of children whose problems were causing concern in the schools. It was partly as a result of this experience that the committee was organized. Naturally, the largest group of cooperative cases has been carried with the agency having the largest number of cases in the area, the county welfare board. In cooperative cases the project has been used as a consulting agency; as an agency giving specialized supplementary service, such as group work or psychological service; and as an agency sharing in the case-work treatment program. The interchange of experience resulting has been of advantage to both agencies.

The growing consciousness of need in the community for further services for children in their own homes has led to an examination of all existing services for children. Statistics released recently by the United States Children's Bureau indicate that St. Paul has an unusually extensive program of foster-home care for children for a city of its size⁶, and the question has arisen whether the foster-home program has been developed at the expense of other services. Under the leadership of the welfare cabinet plans are now being formed to set up an intake committee, representing both children's and family agencies, to study all applications for foster-home care and to consider in each case whether the necessity of removal of the child from his own home might be obviated were adequate services available to make needed adjustments in the home. Here again

⁶ Social Statistics Project: Number of Dependent and Neglected Children Under Care Away From Home, July 1941 and July 1940. Division of Statistical Research, U. S. Children's Bureau, Washington, 1941.

will arise the question of how such service may be obtained.

The county welfare board in particular is concerned about its responsibilities to the children in the families receiving public assistance and to those being referred because of neglect at home or evidence of problems at school. It is taking under consideration ways in which it can make available a sufficient quantity of services and develop the quality of its service to begin to meet some of these needs.

Conclusion.

In conclusion, several aspects of the project should be emphasized. The problem of finding and reaching the child early in the development of his problem behavior is one which requires the mobilization of community resources and the cooperation of the organized forces of the community, particularly the institutions and agencies which come into contact with children in their daily lives. By instituting treatment early it is hoped that the problem of providing treatment may be simplified, that more opportunity for strengthening the home will be found, that less need to resort to authoritative measures will result, and that it will be necessary less frequently to remove the child from his own home.

St. Paul has begun to assess its services for children in their own homes, to question their adequacy, and to ask whether there would be less need for expenditures for institutions and

foster-home care were more service given at the point of first need.

With this questioning of the adequacy of its services and with the development of the movement to coordinate social services and the schools, St. Paul has, in fact, laid the foundation for a community with coordination of preventive, protective, educational, health, and welfare services focused upon the needs of all children.

The project has had a part in stimulating this questioning and in experimenting with types of services which have seemed fruitful. Material developed out of an analysis and evaluation of the project's services in St. Paul should be stimulating to other communities in assessing the adequacy of their own services to children and in planning the development of sound child-welfare programs.

The report on the project to be made at its conclusion will attempt to develop useful material along the lines indicated in this preliminary article. However, it is certain that many more questions will be raised than can be answered by the specific material which the project will have available. In its wider application, as well as in its local setting, the ultimate value of the project will depend on the interest of public-welfare departments in utilizing principles which the project has been developing and in exploring the possibilities of their practice and further development in the broader setting of city or county-wide agencies.

The First Puerto Rican Child Congress—An Achievement in Democracy

BY CHARLES I. SCHOTTLAND

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The First Puerto Rican Child Congress (Primer Congreso del Niño de Puerto Rico), which was held in San Juan, December 4-7, 1941, was born of the determination of socially minded bodies to call attention, in dramatic form, to the needs of the children in Puerto Rico, to compare existing services with the goals set by the White House Conference on Children in

a Democracy, and to see that every citizen of the island as well as continental United States recognizes the problems affecting child life in Puerto Rico. This determination has a background dating from 1920, when the Commissioner of Education of Puerto Rico requested the Children's Bureau "to make a study of all phases of child life on the island." The study,

published in 1923, revealed the serious plight of Puerto Rico and the inadequacy of the economic, social-welfare, health, educational, and other community services for children. Since that time progress has been made toward greater recognition of the importance of the child and of the community's responsibilities.

Authorized by an act of the legislature and organized by an executive committee appointed by the Governor, the Congress had official, as well as popular, recognition and approval.

The Congress was called to order on the evening of December 4, 1941, in San Juan by Miss Herminia Acevedo, President of the Executive Committee. Every walk of life from every part of the island was represented by the 500 delegates and interested persons present, among whom were physicians, teachers, social workers, housewives, Government officials, employers and workers.

The Congress met, without realizing it, on the eve of the entrance of the United States into the war, within sound of hammers and machines building fortifications, barracks, air fields, and other military facilities all over the usually peaceful island.

After the opening presidential remarks, Dr. José M. Gallardo, Acting Governor and Commissioner of Education, addressed the meeting. He was followed by the Children's Bureau representative, Charles I. Schottland, who set forth the goals of the Bureau for our children in this critical period. The Honorable Maria Libertad Gomez set forth the needs of children in Puerto Rico in a comprehensive manner. Dr. Eduardo Garrido Morales, the Puerto Rican Health Commissioner, discussed the present status of health services. Mrs. Angela Negrón Muñoz, out of her long and rich experience as a school teacher, spoke of the problems and needs of school children. Other speakers and guests were introduced and added their testimony regarding the problems and needs of child life on the island.

The next day the Congress divided into six sections to discuss specific fields and programs. Out of these sections came specific recommendations and almost 400 resolutions, which were considered by the Congress.

Section 1, on the home and family in relation to the child, considered problems of urban as

distinct from rural children, the child in a broken home, religion in the life of the child, the child of a working mother, and related subjects. These matters were considered in the light of child life in Puerto Rico, where 90 percent of the housing is substandard, and where poverty, broken homes, and numerous related problems present situations far more serious than in other parts of the United States. Resolutions were presented calling for low-cost housing, enactment of better legislation regarding protection of children of unmarried mothers, extension of child-welfare services, establishment of the social-security programs for public assistance and social insurance, and other measures designed to protect the home as the most important factor in the life of the child.

Section 2 considered the child in relation to the economic and social setting. In view of the fact that children under 18 constitute more than one-half of the population of Puerto Rico and that the birth rate is increasing and the death rate decreasing in an area already one of the most densely populated in the world, the Congress urged measures to slow up population growth through a long-range program of education and economic measures to raise the standard of living. Resolutions affecting all phases of economic life on the island were discussed, and it was recognized that the welfare of the child is dependent primarily on the economic welfare of the family and of the population as a whole.

The physical and mental health of the child were discussed in section 3. This section recognized the serious health problems of Puerto Rico, the undernourishment of large sections of its child population, its high infant mortality rate, its inadequate maternal and child-health programs. Resolutions were considered calling for further study and research in child-health problems, extension of medical services, and particularly maternal and child-health programs, prenatal clinics, more adequate training of midwives, coordination and extension of nutrition services, establishment of child-guidance and mental-hygiene clinics, more and better hospital facilities of all kinds, special training of health personnel, and improvement in prac-

tically every other phase of health services affecting children.

Section 4 considered the problem of education both inside and outside the school. Only 285,000 children, out of a population of 711,000 from 5 to 18 years of age, are in school, and the Congress was emphatic in its declaration that school services need to be extended to every child. Recommendations were also considered concerning the teaching of English in the curriculum, vocational guidance, training for homemaking, higher qualifications for teachers, extension of recreational programs, the place of the second unit (vocational) schools.

The Child and the Law was the subject of section 5. Out of the discussions came numerous resolutions to abolish child labor, protect youth in dangerous occupations, shorten working hours, provide better care for juvenile offenders, extend the jurisdiction of the juvenile court, establish temporary detention homes, provide for psychological and psychiatric services for juvenile offenders, establish special fa-

cilities to house the older juvenile offenders, increase probation services, and to establish or extend all those services or enact those laws necessary to afford adequate protection to the children of Puerto Rico.

Social assistance was the theme of section 6. The section recognized the inadequacies of the present social-welfare programs. It urged aid to dependent children as a method of preserving and maintaining the home, old-age assistance, extension of unemployment and old-age insurance to Puerto Rico, under the Social Security Act, and the establishment or extension of numerous social-welfare programs.

The Congress closed with the firm purpose of pressing forward toward its objectives for the children of Puerto Rico—objectives which, when realized, will enable them to assume their full share of responsibility as citizens. The First Puerto Rican Child Congress is another great democratic achievement—another step in our progress to achieve the “better life.”

BOOK NOTES

YOUTH IN A CATHOLIC PARISH, by Brother Augustine McCaffrey. Catholic University of America Press, Washington, 1941. 310 pp. \$2.

Of interest to social workers in general and to Catholic social workers in particular is this doctoral dissertation. The study deals with the problems and activities of unmarried Catholic youth 16 to 25 years of age in an urban parish. It covers recreational opportunities, youth and the home, youth and religious practice, youth and moral practice, youth and the school, and youth and employment.

FAMILY BEHAVIOR. Second edition. By Bess V. Cunningham. W. B. Saunders Co., Philadelphia, 1940. 527 pp. \$3.

It is becoming increasingly evident, as the years pass, that the contributions of family life to the development and maturation of the child are very great. In many homes, however, the family has encountered obstacles that have greatly interfered with the peaceful serenity of the home thought to be so desirable for the maturing child.

Ability to understand what goes on in family life, ability of each person to understand himself and look

with objectivity on the inevitable problems of all families is an important step in producing acceptable family behavior. Miss Cunningham has prepared this book to be used as a text in colleges to help the college student—the prospective family member—to gain an insight into himself and into the family as an institution.

Miss Cunningham sets her material in a historical background by beginning with a discussion of the origins of the family. She then discusses the family of today in its present social setting, showing how the neighbors and the community impinge upon the family at innumerable points. The adult members of the family have always worked—and probably always will—but whether they work in the home or outside—especially whether the mother works outside the home, makes a great deal of difference in family adjustments. The modern family is likely to have more leisure than families have had in the past, so that a philosophy of leisure is often needed.

In the last few chapters the author considers the family as a place for the molding of personalities.

D. V. W.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

The 1940 Record of Maternal and Infant Mortality in the United States

By J. YERUSHALMY, PH. D.¹

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THE 1940 record of maternal and infant mortality depicts continued gratifying reduction in loss of life associated with childbirth and infancy. This record is of especial significance in view of the present war situation because these gains may be maintained in the immediate future only through the application of great effort and energy.

The dislocation of a large portion of the population resulting from the war effort may have serious consequences to the welfare of the American home and family. The explosive increase in population in many localities imposes great strains on the housing, sanitary, and hospital facilities of the communities. There is also an acute shortage of medical and nursing personnel in many areas. In addition, women are entering into industrial employment in continuously increasing numbers. All these considerations may tend to block the progress that has been made in recent years in the saving of lives of mothers and infants. The presentation of the maternal and infant mortality record for 1940 at this time may therefore serve not only as a measure of past accomplishments but also as a base line for evaluating the success with which the very difficult problems of the immediate future will be met.

The record for 1940 is favorable not only in terms of mortality rates of mothers and infants, but also in that the birth rate was higher than

for any year since 1931. Continued gains were also recorded in the proportion of births in hospitals and in the proportion of births attended by medical persons. In spite of these gains the problem presented by the loss of life associated with childbirth and early infancy is challenging. The magnitude of this problem may be judged from the single figure of 193,548 lives that have been lost in 1940 through maternal mortality, stillbirth, and infant mortality. This figure, it should be noted, is an underestimate because still-birth registration is known to be incomplete in many sections of the country.

A summary of the maternal and infant mortality and birth statistics for 1940 which have just been issued by the Division of Vital Statistics of the Bureau of the Census² is presented here, together with a comparison of the 5-year periods 1936-40 and 1931-35. Statistics for stillbirths are excluded because of the known deficiencies in the registration of stillbirths in the country and the inequalities in completeness of stillbirth registration in the various States.

MATERNAL MORTALITY, 1940

In 1940, 8,876 women died from causes directly due to pregnancy and childbirth. The maternal mortality rate for the year was 37.6 per 10,000 live births. This rate is 7 percent lower than that for 1939 (40.4), and 43 percent lower than the rate at the beginning of the last decade (67). Of the 8,876 women who died

¹ Grateful acknowledgment is made to Hannah S. Rifkind, of the Division of Statistical Research, for her assistance in assembling the material.

² Bureau of the Census: Vital Statistics—Special Reports. Washington, 1941.

6,614 were white women, 2,180 were Negro, and 82 were women of other races. The 1940 maternal mortality rate for Negro women (78) was nearly $2\frac{1}{2}$ times as high as that for white women (32). The reduction in the maternal mortality rate from 1939 to 1940 was accounted for entirely by the reduction in the rate for white women from 35 to 32.

It is encouraging to note the remarkably low rates in some of the States^a (table 1). North Dakota established a new low record for maternal mortality in any State with the rate of 17.2 per 10,000 live births. Other low rates were attained by Minnesota, Rhode Island, and Oregon. In view of the low rates attained by some of the States it may not be too optimistic to hope that the country as a whole will attain further considerable reductions in the maternal mortality rate. This hope is strengthened by the fact that in a number of States the maternal mortality rate has been consistently low. North Dakota, for example, has been among the States with the lowest rates for several years. On the other side of the scale are the States with extremely high rates. The highest rate (67.8) is recorded for South Carolina. Other high rates are recorded for Alabama and Florida. In general, the rates were highest in the South and lowest in the northern part of the Midwest and West (fig. 1). Sixteen States had rates of less than 30 per 10,000 live births; 15 had rates of 30-39; 9 had rates of 40-49; and 9 had rates of 50 or higher.

In 31 States the maternal mortality rates were lower than in 1939, and in 18 States the rates were higher. No great significance can be attached to yearly fluctuation in rates in States in which a relatively small number of births is involved.

Causes of Maternal Death.

The causes of maternal death may conveniently be grouped under three major headings—infection, toxemias, and the group hemorrhage, trauma, or shock. These causes were responsible for 89 percent of the 8,876 maternal deaths in 1940 (table 2). The remain-

TABLE 1.—*Maternal mortality rates in each State, 1940 and 1939*

State (number of deaths in 1940)	Maternal mortality rate ¹	
	1940	1939
United States (8,876).....	37.6	40.4
Alabama (386).....	61.3	58.8
Arizona (59).....	50.2	43.9
Arkansas (187).....	45.7	56.8
California (312).....	27.9	31.0
Colorado (86).....	40.7	53.6
Connecticut (71).....	28.2	25.6
Delaware (25).....	54.4	41.1
District of Columbia (45).....	26.4	62.0
Florida (219).....	64.8	65.3
Georgia (370).....	56.9	55.9
Idaho (42).....	35.9	21.7
Illinois (366).....	26.7	31.4
Indiana (178).....	28.7	36.0
Iowa (159).....	32.0	29.9
Kansas (107).....	37.3	37.1
Kentucky (229).....	36.0	43.2
Louisiana (272).....	53.4	61.8
Maine (61).....	40.3	39.4
Maryland (84).....	27.8	37.1
Massachusetts (186).....	28.1	35.2
Michigan (289).....	29.2	30.6
Minnesota (118).....	22.2	29.5
Mississippi (330).....	62.8	59.4
Missouri (229).....	36.8	41.3
Montana (35).....	30.5	32.1
Nebraska (71).....	32.0	34.9
Nevada (10).....	45.6	41.2
New Hampshire (27).....	31.8	34.0
New Jersey (175).....	29.9	32.3
New Mexico (69).....	46.8	49.9
New York (585).....	29.7	32.1
North Carolina (416).....	51.6	47.3
North Dakota (29).....	17.2	24.3
Ohio (370).....	32.2	38.8
Oklahoma (177).....	39.7	40.5
Oregon (45).....	25.2	23.9
Pennsylvania (538).....	32.5	38.1
Rhode Island (27).....	25.0	33.6
South Carolina (301).....	67.8	59.1
South Dakota (40).....	34.4	29.3
Tennessee (265).....	47.6	55.7
Texas (583).....	46.0	48.7
Utah (36).....	26.6	30.8
Vermont (24).....	35.9	36.1
Virginia (248).....	44.9	50.6
Washington (86).....	30.6	36.8
West Virginia (140).....	33.3	32.7
Wisconsin (154).....	28.1	27.9
Wyoming (21).....	41.6	34.7

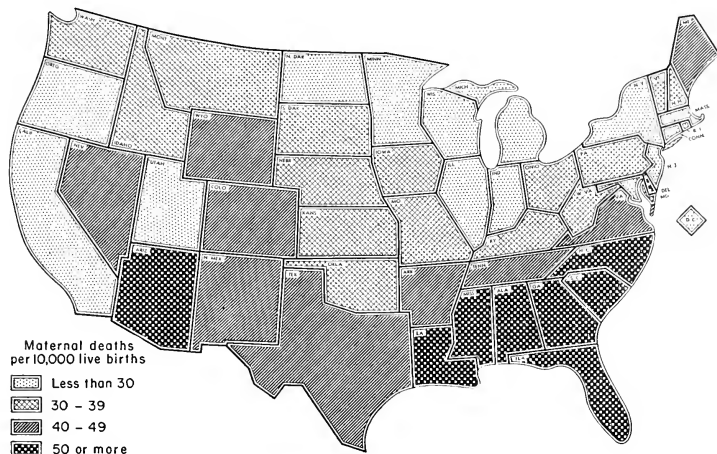
¹ Deaths due directly to diseases of pregnancy, childbirth, and the puerperium per 10,000 live births.

ing 942 deaths were due to other and unspecified causes.

Infection was the leading cause of maternal mortality and was responsible for 3,626 (41 percent) of the maternal deaths. The death rate from this cause was 15.4 per 10,000 live births. In the majority of instances death was due to infection classified as "general or local." Thrombosis, thrombophlebitis, embolism and other infections were responsible for 745 deaths, and pyelitis and pyelonephritis for 106.

^a The term "States" as used in this article includes the District of Columbia.

FIG. 1.—MATERNAL MORTALITY RATE IN EACH STATE, UNITED STATES, 1940.



Based on data from U. S. Bureau of the Census

Next in numerical importance were toxemias, which accounted for 2,250 (25 percent) of the maternal deaths. The death rate from this cause was 9.5 per 10,000 live births. Eclampsia was responsible for 52 percent of these deaths, albuminuria and nephritis not specified as chronic for 27 percent, and other toxemias for 21 percent.

Hemorrhage, trauma, or shock was the cause of 2,058 (23 percent) of the maternal deaths. The death rate from this cause was 8.7 per 10,000 live births. Placenta previa was mentioned for 252 of these 2,058 deaths; premature separation of the normally implanted placenta, for 196.

Physicians failed to give satisfactory information as to cause of death for 942 (11 percent) of the maternal deaths. These deaths included 304 that occurred before delivery for which

the physicians stated the cause in general terms such as pregnancy, multiple pregnancy, or death of fetus in utero, and 159 as following abortion but not assigned to one of the three principal groups of cause of death. For the remaining 479, which occurred during or after childbirth, the physician's statement indicated little more than that a child had been born to the mother and that the birth was the most important factor in the death. The lack of information for this considerable number of deaths indicates the need for improvement in the statement of cause of death on the certificate.

Maternal Deaths, by Time of Death and in Relation to Delivery.

The maternal deaths for 1939 and 1940 were tabulated in accordance with the 1938 revision of the International List of Causes of Death.

This revision affords additional information which was not available for prior years in that it is possible to classify the deaths roughly according to outcome of pregnancy. The deaths are tabulated in four classifications as those associated with abortion, ectopic gestation, deaths before delivery, and deaths during or after delivery. The last is defined as following a uterine pregnancy of 7 lunar months (28 weeks) or more of gestation. The termination of a uterine pregnancy prior to 7 lunar months of gestation is considered an abortion.

Of the 18,027 maternal deaths which occurred in 1939 and 1940, 19 percent (3,468) were stated to have occurred during or after abortion. Slightly more than 4 percent (766) resulted from ectopic gestation, 2,676 (15 percent) of the women died before delivery, and 11,117 (62 percent) occurred during or after childbirth.

The classification of maternal deaths according to time of death in relation to delivery makes possible a cross-tabulation of the maternal deaths, both by cause of death and by time of death in relation to delivery. The data for 1940 are presented in table 2. From this table it is possible to determine, on the one hand, the distribution of the major causes of maternal deaths for the various classifications of time

of death in relation to delivery and, on the other hand, the distribution as to the time of delivery for each of the major causes of death. Thus, it will be seen that nearly four-fifths of the women whose deaths were stated to have occurred during or after abortion died from infection, and that a very small proportion of them died from toxemias. On the other hand nearly three-fourths of the women who died before delivery were stated to have died from toxemias and none from infection.

Of the 5,504 women who died during or after childbirth 40 percent died from infection, 29 percent died from hemorrhage, trauma, or shock, and 22 percent died from toxemias.

Of the 3,626 women who died from infection 61 percent died during or after childbirth, none died before delivery, 37 percent died during or after abortion, and slightly more than 2 percent had ectopic pregnancies. The corresponding percentages for the 2,250 women who died from toxemias were 55, 42, 3, and 0, respectively. For the 2,058 women who died from hemorrhage, trauma, or shock, the corresponding percentages were 77, 3, 5, and 15, respectively.

In general the distribution of the maternal deaths according to time of death in relation

TABLE 2.—Maternal deaths¹ from each cause, and time of death in relation to delivery: United States, 1940

Cause of death	Total	Ectopic gestation	During or after abortion	Before delivery	During or after childbirth
Number					
All causes.....	8,876	392	1,682	1,298	5,504
Infection.....	3,626	85	1,334		2,207
Toxemias.....	2,250		80	939	1,231
Eclampsia.....	1,168			425	743
Albuminuria and nephritis.....	617			294	333
Other toxemias.....	465		80	230	155
Hemorrhage, trauma, or shock.....	2,058	307	106	55	1,587
Other and unspecified causes.....	942		159	304	479
Percent					
All causes.....	100	100	100	100	100
Infection.....	41	22	79		40
Toxemias.....	25		5	73	22
Eclampsia.....	13			33	13
Albuminuria and nephritis.....	7			22	6
Other toxemias.....	5		5	18	3
Hemorrhage, trauma, or shock.....	23	78	7	4	29
Other and unspecified causes.....	11		9	23	9

¹ Deaths due directly to diseases of pregnancy, childbirth, and the puerperium.

to delivery was similar for most of the States. There were, however, a few notable exceptions. For example, in the District of Columbia a much higher proportion of the deaths was associated with abortion (33 percent) and ectopic gestation (13 percent), and only 41 percent were stated to have occurred during or after delivery. On the other hand, in Utah,

TABLE 3.—Percentage distribution of maternal deaths¹ by time of death in relation to delivery in each State, 1939-40

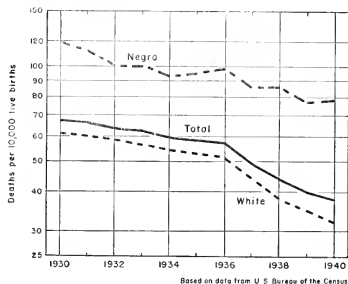
State (number of deaths in 1939-40)	Death in relation to delivery			
	Abortion	Ectopic gestation	Before delivery	During or after childbirth
Percent of total maternal deaths				
United States (18,027)	19	4	15	62
Alabama (747)	17	3	16	64
Arizona (107)	20	5	18	57
Arkansas (389)	22	3	18	57
California (633)	22	4	8	66
Colorado (197)	25	5	16	54
Connecticut (131)	14	2	11	73
Delaware (43)	16	3	16	65
District of Columbia (118)	33	13	13	41
Florida (430)	18	4	20	58
Georgia (732)	15	3	19	63
Idaho (66)	21	3	8	68
Illinois (736)	21	7	11	61
Indiana (388)	25	5	16	54
Iowa (290)	22	8	11	58
Kansas (215)	26	3	11	60
Kentucky (491)	17	2	13	68
Louisiana (374)	20	4	21	55
Maine (129)	14	2	15	69
Maryland (189)	23	7	13	57
Massachusetts (410)	19	3	10	68
Michigan (578)	22	5	11	62
Minnesota (266)	23	4	12	61
Mississippi (637)	13	3	22	62
Missouri (472)	23	5	9	63
Montana (70)	29	1	9	61
Nebraska (149)	22	4	11	63
Nevada (18)	22	11	6	61
New Hampshire (54)	11	7	26	56
New Jersey (357)	21	6	14	59
New Mexico (140)	14	2	14	70
New York (1,188)	23	6	8	63
North Carolina (790)	12	2	26	60
North Dakota (55)	20	11	13	56
Ohio (794)	22	5	14	59
Oklahoma (353)	17	4	20	59
Oregon (85)	22	7	21	50
Pennsylvania (1,151)	22	5	10	63
Rhode Island (62)	19	3	18	60
South Carolina (554)	13	2	21	64
South Dakota (74)	20	3	13	64
Tennessee (562)	20	3	19	58
Texas (1,173)	17	4	19	60
Utah (76)	9	2	7	82
Vermont (47)	21	6	13	60
Virginia (516)	19	3	14	64
Washington (181)	17	4	18	61
West Virginia (276)	13	4	14	69
Wisconsin (305)	13	7	17	73
Wyoming (38)	21	3	21	55

¹ Deaths due directly to diseases of pregnancy, childbirth, and the puerperium.

Wisconsin, Connecticut, and New Mexico a relatively high proportion of the maternal deaths occurred during or after delivery and a smaller proportion of the deaths were due to abortion. The proportion of the deaths stated to have occurred before delivery also varied considerably among the States. Thus, about one-quarter of all the maternal deaths in three States occurred before delivery, whereas in a number of States less than one-tenth of the maternal deaths occurred before delivery (table 3).

Maternal mortality rates for white and Negro women from 1930 to 1940 are shown in figure 2. The mortality rate for both white

FIG. 2.—MATERNAL MORTALITY RATES, BY RACE, UNITED STATES EXPANDING BIRTH-REGISTRATION AREA, 1930-40.



and Negro women decreased during this period. The decrease was relatively slight up to 1936 and has been accelerated considerably since that year. Thus, the period in which the greatest reduction occurred coincides with the period of increased State and local activity in maternal and child-health work made possible through Federal and State cooperation under the Social Security Act. The relative decrease has been greater for white women than for Negro women. The 1940 rate for white women was 48 percent lower than the 1930 rate, whereas for Negro women the rate for 1940 was only 34 percent lower than the 1930 rate.

Maternal Mortality, 1936-40 and 1931-35.

During the 5-year period 1936-40 there occurred in the country 11,261,076 live births. In the same period there occurred 50,931 maternal deaths. The maternal mortality rate for this period was therefore 45.2 per 10,000 live births. During the period 1931-35 there occurred 10,590,775 live births and 65,372 maternal deaths, and the maternal mortality rate was 61.7. There was, therefore, a reduction of 27 percent in the maternal mortality rate. If the rate for the first 5-year period were operating also through 1936-40 there would have occurred 69,481 maternal deaths; consequently the reduction in maternal mortality is equivalent to a saving of the lives of 18,550 mothers during the 5-year period.

There was considerable reduction in the mortality rate from each of the major causes of death, but the size of the decrease was not uniform for all causes.⁴ The reduction was largest for deaths from infection (31 percent). The rate from toxemias decreased 24 percent, and the smallest percentage reduction occurred from hemorrhage, trauma, or shock (16 percent). The relatively large decrease in the rate from "all other puerperal causes" (26 percent) reflects also an improvement in the more specific statement of cause of death by the physicians.

The reduction in the maternal mortality rate in 1936-40 compared with 1931-35 has not been of the same size in all States (table 4). It is, however, encouraging to note that in no State

TABLE 4.—Percentage decrease in the maternal mortality rate in each State, 1936-40 compared with 1931-35

State	Percent decrease	Maternal mortality rate ¹	
		1936-40	1931-35
United States.....	26.7	45.2	61.7
Alabama.....	9.2	65.0	71.6
Arizona.....	20.8	55.5	71.3
Arkansas.....	11.3	60.4	68.1
California.....	30.6	55.2	50.7
Colorado.....	26.7	52.1	71.1
Connecticut.....	37.4	29.0	46.3
Delaware.....	24.4	52.1	68.9
District of Columbia.....	18.2	51.6	63.1
Florida.....	28.1	70.5	98.0
Georgia.....	19.4	66.9	83.0
Idaho.....	31.7	37.3	54.6
Illinois.....	32.4	35.5	52.5
Indiana.....	36.7	38.7	57.5
Iowa.....	27.7	37.8	52.3
Kansas.....	28.0	43.2	60.0
Kentucky.....	20.7	44.7	56.4
Louisiana.....	19.2	66.0	81.7
Maine.....	26.5	48.5	66.0
Maryland.....	28.9	38.1	53.6
Massachusetts.....	35.3	39.3	60.7
Michigan.....	36.6	36.9	68.2
Minnesota.....	35.1	32.2	46.5
Mississippi.....	7.8	64.2	69.6
Missouri.....	28.0	45.7	63.5
Montana.....	38.8	37.2	60.8
Nebraska.....	26.2	38.9	52.7
Nevada.....	30.4	53.0	76.2
New Hampshire.....	37.5	39.2	62.7
New Jersey.....	34.5	55.4	63.7
New Mexico.....	29.7	55.1	78.4
New York.....	34.2	37.7	57.3
North Carolina.....	22.9	54.2	70.3
North Dakota.....	36.4	30.9	48.6
Ohio.....	34.5	40.8	62.3
Oklahoma.....	25.9	46.9	63.3
Oregon.....	33.4	34.9	62.4
Pennsylvania.....	29.6	41.8	59.4
Rhode Island.....	39.6	32.8	54.3
South Carolina.....	19.0	74.1	91.5
South Dakota.....	25.8	37.3	50.3
Tennessee.....	14.1	57.7	67.2
Texas.....	28.0	55.1	74.5
Utah.....	26.1	32.8	44.4
Vermont.....	31.4	42.9	62.5
Virginia.....	20.8	52.2	65.9
Washington.....	31.5	39.0	56.9
West Virginia.....	25.4	41.6	53.8
Wisconsin.....	29.4	32.6	44.3
Wyoming.....	36.7	39.3	62.1

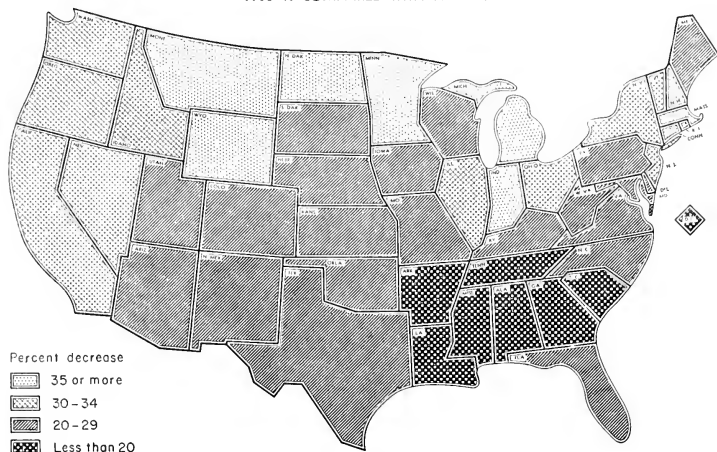
¹ Deaths due directly to diseases of pregnancy, childbirth, and the puerperium per 10,000 live births.

² Rates for South Dakota and Texas are for 4 and 3 years, respectively, as these States were not in the birth-registration area during the entire period.

⁴ The discussion of the percentage reduction by cause is complicated by the fact that there has occurred in the meantime a change in the International List of the Causes of Death. The deaths for 1939-40 were classified according to the 1938 revision whereas the deaths for the previous years were classified according to the 1929 revision. Deaths certified as due to criminal abortion (157 in 1939 and 150 in 1940) and to acute yellow atrophy of the liver (55 in 1939 and 51 in 1940) are now classified as maternal deaths. (Such deaths were classified as homicide and as diseases of the digestive system, respectively, in earlier revisions of the International List.) The maternal mortality rate per 10,000 live births was 40.4 for 1939 and 37.6 for 1940; without these new inclusions, it would have been 39.5 and 36.8, respectively, or about 2 percent lower each year than the published rate. If the method of classification used had been that in use in the years immediately preceding 1938, reductions in the mortality rate from diseases of pregnancy, childbirth, and the puerperium in 1936-40 compared with 1931-35 would have been somewhat greater than shown here. This understatement of improvement is also present in the groups of separate causes: infection, toxemias, and hemorrhage.

was the 1936-40 rate as high as the 1931-35 rate. Reductions of 25 percent or more occurred in Rhode Island, Montana, New Hampshire, Connecticut, Wyoming, Michigan, North Dakota, Indiana, Massachusetts, and Minnesota. The smallest reductions occurred in Mississippi, Alabama, Arkansas, and Tennessee. In 8 States the decrease was less than 20 percent; in 21 States, 20 to 29 percent; in 10 States, 30 to 34

FIG. 3.—PERCENTAGE DECREASE IN THE MATERNAL MORTALITY RATE IN EACH STATE, 1936-40 COMPARED WITH 1931-35.



Based on data from U. S. Bureau of the Census

percent; and in 10 States 35 percent or more, compared with the rate for 1931-35 (fig. 3).

The decrease in the maternal mortality rate was more than twice as large for white women as for women of nonwhite races. The average maternal mortality rate for white women for the period of 1931-35 was 56.4 per 10,000 live births; for 1936-40 the rate was 39.7, a reduction of 30 percent. The corresponding rates for women of other races were 97.1 and 84.1, a reduction of only 13 percent. The largest reduction among white women occurred in the rates from infection (34 percent) and from "all other puerperal causes" (31 percent). The reduction from toxemias was 27 percent and from hemorrhage, trauma, or shock, 16 percent. For women of other races corresponding reductions were in deaths from infection (20 percent), toxemias (12 percent), hemorrhage (8 percent), and "all other puerperal causes" (6 percent).

INFANT MORTALITY, 1940

The number of infant deaths in 1940 was 110,984. The infant mortality rate for the year was 47 per 1,000 live births as compared with a rate of 48 for 1939. This is an all-time low record and represents a decrease of 28 percent from the 1930 rate (65). The decrease from 1939 to 1940 in the infant mortality rate was accounted for entirely by the reduction in the rate for white infants from 44 to 43. The rate for Negro infants (73) was the same as for the previous year.

Of the 110,984 infant deaths 67,866 (61 percent) were neonatal deaths (deaths of infants under 1 month of age). The neonatal mortality rate was 28.8 per 1,000 live births, and the mortality of infants from 1 to 11 months of age was 18.8 per 1,000 infants alive at the beginning of the second month. The mortality among infants on the first day of life accounted

for 30 percent of all the infant deaths. In 1930, 55 percent of the infant deaths occurred under 1 month and only 23 percent occurred under 1 day of age.

The infant and neonatal mortality rate and the mortality rates at ages 1 to 11 months are shown for each State in table 5. It will be seen that some of the States attained rates which were considerably lower than those for the country as a whole. Minnesota and Oregon set a new all-time low State record with an

TABLE 5.—*Infant mortality rates, by age, in each State, 1940 and 1939*

State	Under 1 year ¹		Under 1 month ¹		1-11 months ²	
	1940	1939	1940	1939	1940	1939
United States.....	47.0	48.0	28.8	29.3	18.8	19.3
Alabama.....	61.4	59.9	36.7	35.5	25.6	25.2
Arizona.....	84.3	94.3	35.6	34.6	50.5	61.9
Arkansas.....	45.7	46.0	23.5	25.0	22.7	21.6
California.....	39.4	42.4	25.4	26.2	14.4	16.6
Colorado.....	59.8	54.8	33.2	29.6	27.6	25.9
Connecticut.....	34.1	35.9	25.0	25.4	9.3	10.8
Delaware.....	48.9	44.0	26.8	22.8	22.8	21.7
District of Columbia.....	47.0	47.7	33.0	31.1	14.5	17.1
Florida.....	53.6	56.4	33.6	35.3	20.7	21.8
Georgia.....	57.9	58.4	35.1	35.1	23.6	24.0
Idaho.....	42.3	45.9	26.7	29.6	16.0	16.8
Illinois.....	35.3	38.0	24.1	25.6	11.5	12.7
Indiana.....	41.9	39.5	26.3	24.7	16.0	15.1
Iowa.....	36.7	38.8	25.1	26.3	11.9	12.8
Kansas.....	38.1	39.4	24.1	26.4	14.4	13.3
Kentucky.....	52.8	52.6	32.2	31.2	21.3	22.1
Louisiana.....	64.2	63.0	36.7	35.6	28.6	28.4
Maine.....	53.5	52.4	34.6	33.1	19.6	19.9
Maryland.....	49.6	50.3	28.8	27.5	21.3	23.4
Massachusetts.....	37.5	37.0	25.3	25.3	12.5	12.0
Michigan.....	40.7	41.9	26.5	27.5	14.6	14.8
Minnesota.....	33.3	35.8	23.4	25.0	10.1	11.1
Mississippi.....	54.3	56.2	30.7	31.6	24.4	25.4
Missouri.....	46.9	45.1	28.0	27.9	19.4	17.7
Montana.....	46.2	49.0	29.8	29.1	16.9	20.5
Nebraska.....	35.7	36.5	24.0	25.4	12.0	11.4
Nevada.....	51.9	44.8	30.5	24.2	22.0	21.1
New Hampshire.....	40.0	44.3	24.3	30.5	16.0	15.7
New Jersey.....	35.6	38.7	24.2	25.1	11.7	14.0
New Mexico.....	99.6	109.0	41.6	48.3	60.4	63.7
New York.....	37.2	39.3	25.4	26.2	12.0	13.5
North Carolina.....	57.4	59.2	33.4	32.9	24.9	27.2
North Dakota.....	45.1	49.0	29.1	32.2	16.5	17.4
Ohio.....	41.4	42.9	26.9	27.7	14.9	15.7
Oklahoma.....	49.7	49.7	29.5	31.1	20.8	19.3
Oregon.....	32.9	35.5	23.1	22.9	10.1	12.9
Pennsylvania.....	44.7	45.6	28.4	29.1	16.8	17.0
Rhode Island.....	38.2	39.4	26.2	27.2	12.4	12.6
South Carolina.....	68.1	66.2	36.5	37.9	32.8	29.4
South Dakota.....	39.2	41.4	27.6	26.3	11.9	15.5
Tennessee.....	54.7	53.9	30.2	31.3	25.2	23.3
Texas.....	68.6	67.0	34.2	33.7	35.6	34.4
Utah.....	40.6	39.5	27.8	28.4	13.2	11.4
Vermont.....	45.0	45.6	30.6	29.6	14.8	16.5
Virginia.....	59.3	60.9	34.9	36.8	25.2	25.0
Washington.....	35.7	36.8	24.6	25.5	11.4	11.5
West Virginia.....	53.9	54.7	31.4	30.8	23.3	24.7
Wisconsin.....	37.2	40.2	25.3	27.5	12.2	13.0
Wyoming.....	46.3	45.5	26.1	28.4	20.7	17.7

¹ Deaths per 1,000 live births.

² Deaths per 1,000 infants surviving the first month of life.

infant mortality rate of 33. Connecticut came next with a rate of 34. At the other end of the scale were New Mexico, with a rate of 100, and Arizona, with a rate of 84. The next highest rate was in Texas (69). As in the case of maternal mortality, some of the States have had consistently low infant mortality rates for a number of years. This record strengthens the belief that what can be attained by some of the States can eventually be attained by the country as a whole. The infant mortality rates were again highest in the Southern States and lowest in the Midwestern States.

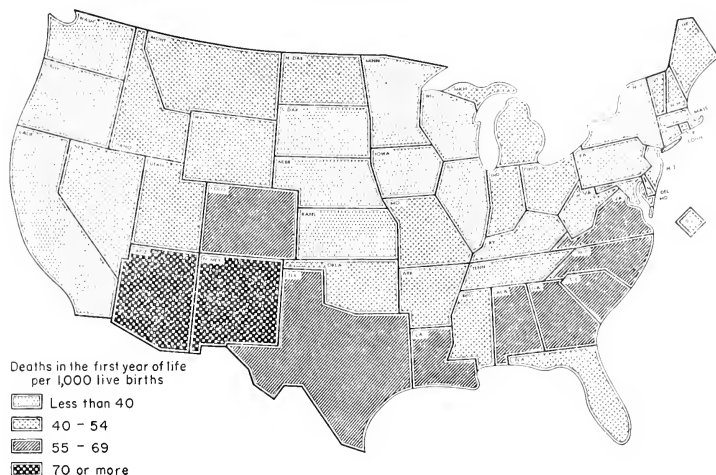
Fifteen States had rates of less than 40 per 1,000 live births, 24 had rates of 40 to 54, 8 had rates of 55 to 69, and 2 had rates of 70 or more (fig. 4). Seven of the 10 States that had rates of 55 and higher were Southern States and 3 were Western States. In 33 States infant mortality rates were lower in 1940 than in 1939, in 15 States the rates were higher, and in 1 State the rate was the same as in 1939. In most of the States with higher rates the increases were not large.

Causes of Infant Deaths.

It may be convenient to separate from the causes of infant deaths those which have their origin in utero or at birth. These include the causes which are usually referred to as prenatal and natal causes. These include premature birth, congenital malformation, injury at birth, congenital debility, "other diseases peculiar to early infancy," syphilis, and tetanus. All these causes were responsible in 1940 for 64,017 (58 percent) of the infant deaths. The other important causes of infant death were respiratory diseases, which accounted for 18,838 (17 percent) of the deaths; gastrointestinal diseases which accounted for 9 percent; and communicable diseases, 3 percent.

Prenatal and natal causes took their heaviest toll in the first month of life. Nearly 90 percent of all the deaths from these causes occurred in the first month of life, whereas more than three-fourths of the deaths from all other causes occurred after the first month of life. Of all the deaths in the first month of life, 84 percent were due to prenatal and natal causes; more

FIG. 4.—INFANT MORTALITY RATE IN EACH STATE, UNITED STATES, 1940.



Based on data from U S Bureau of the Census

than half of these were due to premature birth, which was the largest single cause of infant mortality. Premature birth was responsible

TABLE 6.—Infant deaths, by age, and by cause; United States, 1940

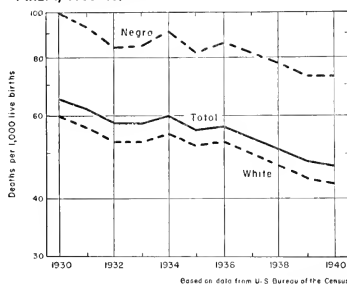
Cause of death	Under 1 year	Under 1 month	1-11 months
All causes	110,984	67,866	43,118
Prenatal and natal causes	64,017	57,325	6,692
Premature birth	32,346	31,437	909
Congenital malformations	11,638	7,608	3,430
Injury at birth	10,506	10,280	226
Congenital debility	2,827	1,794	1,053
Other diseases peculiar to the first year of life	5,914	5,462	452
Syphilis	1,251	619	632
Tetanus	135	125	10
Respiratory diseases	18,838	3,256	15,582
Gastrointestinal diseases	9,814	1,320	8,494
Epidemic and other communicable diseases	3,101	188	2,913
All other specified causes	9,531	2,505	7,026
Ill-defined and unknown causes	5,693	3,272	2,411

for nearly one-third of all infant deaths, with a rate of 13.7 per 1,000 live births. The distribution of the infant deaths by cause of death and age at death is shown in table 6.

The decrease in the infant mortality rate from 1930 to 1940, although considerable, was not so large as the decrease in maternal mortality. The 1940 infant mortality rate was lower than the 1930 rate by 28 percent. The corresponding figure for maternal mortality was 43 percent. The corresponding decrease in the previous decade had been the reverse, however, showing a much greater reduction in infant mortality and only a small decrease in maternal.

The trend of the rates from 1930 to 1940 is shown in figure 5.

FIG. 5.—INFANT MORTALITY RATES, BY RACE, UNITED STATES EXPANDING BIRTH-REGISTRATION AREA, 1930-40.



Infant Mortality, 1936-40 and 1931-35.

The infant mortality rate for the period 1936-40 was 12 percent lower than that for 1931-35. In the first 5 years of the last decade there occurred 620,775 infant deaths, with an infant mortality rate of 58.6 per 1,000 live births. During the period 1936-40 there occurred 578,998 infant deaths with a rate of 51.4. If the rate for the first 5-year period had been operating also during 1936-40, there would have occurred 659,899 infant deaths. Consequently, the reduction in infant mortality is equivalent to a saving of 80,901 infant lives. The reduction in both maternal and infant mortality rates in the 5-year period 1936-40 from the previous 5-year period is

TABLE 7.—Percentage decrease in the infant mortality rate from each cause, by age; United States, 1936-40 compared with 1931-35

Cause of death	Under 1 year	Under 1 month	1-11 months
All causes.....	12	10	16
Prenatal and natal causes.....	8	8	14
Premature birth.....	8	8	17
Congenital malformations.....	12	14	(1)
Injury at birth.....	4	2	(1)
Other prenatal and natal causes.....	12	8	21
Respiratory diseases.....	12	22	11
Gastrointestinal diseases.....	14	25	14
Epidemic and other communicable diseases.....	38	50	37
All other specified causes.....	13	13	15
Ill-defined and unknown causes.....	22	26	14

¹ No change.

equivalent, therefore, to the saving of some 100,000 lives of mothers and infants.

The reduction in infant mortality rates has not been uniform in the entire span of the first year of life. The decrease in the mortality rate of infants 1 month to 11 months of age was much larger than that of infants under 1 month of age. There was a reduction of 16 percent in the mortality rate of the former

TABLE 8.—Percentage decrease in the infant mortality rate in each State, 1936-40 compared with 1931-35

State	Percent decrease	Infant mortality rate ¹	
		1936-40	1931-35
United States.....	12.3	51.4	58.6
Alabama.....	2.2	62.2	63.6
Arizona.....	3.6	102.7	106.5
Arkansas.....	8	49.6	50.0
California.....	13.0	46.0	52.9
Colorado.....	12.8	64.1	73.5
Connecticut.....	23.0	37.6	48.8
Delaware.....	19.4	54.5	67.6
District of Columbia.....	17.9	54.4	66.3
Florida.....	9.9	57.3	63.6
Georgia.....	9.2	63.0	69.4
Idaho.....	8.3	45.5	49.6
Illinois.....	21.6	40.7	51.9
Indiana.....	18.1	44.7	54.6
Iowa.....	14.4	41.6	48.6
Kansas.....	12.5	43.4	49.6
Kentucky.....	6.1	58.3	62.1
Louisiana.....	2.4	66.2	67.8
Maine.....	12.9	58.3	66.9
Maryland.....	18.4	56.9	69.7
Massachusetts.....	20.4	40.9	51.4
Michigan.....	14.0	45.0	52.3
Minnesota.....	18.9	38.5	47.5
Mississippi.....	2.7	56.8	58.4
Missouri.....	13.2	51.4	59.2
Montana.....	10.6	49.6	55.5
Nebraska.....	14.7	39.0	45.7
Nevada.....	27.7	50.1	69.3
New Hampshire.....	45.0	45.4	37.4
New Jersey.....	21.0	39.5	50.0
New Mexico.....	13.0	112.2	129.0
New York.....	21.0	41.7	52.8
North Carolina.....	9.4	63.9	70.5
North Dakota.....	15.3	49.2	58.1
Ohio.....	17.4	45.6	55.2
Oklahoma.....	3.5	52.9	54.8
Oregon.....	7.0	38.4	41.3
Pennsylvania.....	17.2	47.5	57.4
Rhode Island.....	21.2	43.4	55.1
South Carolina.....	7.3	74.0	79.8
South Dakota.....	17.1	44.7	53.9
Tennessee.....	12.0	60.2	68.4
Texas.....	5.3	69.1	73.0
Utah.....	8.9	44.1	48.4
Vermont.....	11.0	49.3	55.4
Virginia.....	7.1	65.9	70.9
Washington.....	11.5	39.1	44.2
West Virginia.....	12.8	60.7	69.6
Wisconsin.....	15.2	42.0	49.5
Wyoming.....	9.5	51.2	56.6

¹ Deaths under 1 year per 1,000 live births.

² Rate for South Dakota and Texas are for 4 and 3 years, respectively, as these States were not in the birth-registration area during the entire period.

during the period, while the decrease in the neonatal mortality rate was only 10 percent.

The decrease in the infant mortality rates from all causes of death was also not uniform (table 7). It was smallest in the group of deaths from prenatal and natal causes (8 percent), and largest in the group of deaths from epidemic and communicable diseases (38 percent). There was a reduction of 14 percent in the rate of deaths from gastrointestinal diseases, and 12 percent from respiratory diseases. The decrease in the mortality rate from premature birth was approximately the same as that from all prenatal and natal causes. The mortality rate from premature birth during the period 1931-35 was 15.8 per 1,000 live births and for the period 1936-40 the rate was 14.6. The decrease was therefore 8 percent.

The reduction in the infant mortality rate in 1936-40 compared with 1931-35 was largest in Nevada, Connecticut, Illinois, and Rhode Island. In some States there was very little reduction as, for example, in Arkansas, Alabama, Louisiana, and Mississippi. (Table 8).

In 6 States the decrease in the infant mortality rate was less than 5 percent; in 11 States the decrease was 5 to 9 percent; in 14 States, 10 to 14 percent; in 10 States, 15 to 19 percent; and in 8 States, 20 percent or more.

BIRTHS

The number of live births registered in 1940 was 2,360,399, and the birth rate was 17.9 per 1,000 population. This is a higher birth rate than for any year since 1931. About half (1,124,812) of the births occurred in rural areas and half (1,235,587) in urban areas, that is, cities of 10,000 or more population.

These figures, it should be noted, represent the places where the births occurred and not where the mothers resided. The tabulations by residence have not yet been released by the Bureau of the Census. It was, however, possible to obtain through the cooperation of the Vital Statistics Division of the Bureau of the Census the information that more than half a million births (500,920—more than one-fifth of all births in 1940) occurred in areas that were different from the residence of the mother. Thus, it may be assumed that, as in previous

years, a large number of women traveled from rural to urban places to be delivered, the majority in hospitals. It is hoped that the detailed information, when it becomes available, will indicate whether or not hospital facilities are within sufficiently easy reach of the rural population and what areas need increased facilities.

Of the infants whose births were registered 2,067,953 (88 percent) were white; 278,869 (12 percent) were Negro; and 13,577 (less than 1 percent) were of other races.

Physicians attended 91 percent of the births, but 218,360 (9 percent) were attended by midwives and other nonmedical persons. The proportion of Negro births which were attended by nonmedical persons was very high (51 percent), whereas only 4 percent of the white infants were so attended. Of the births that occurred in the rural areas 17 percent had no medical attendant (7 percent among white and 75 percent among Negro infants), compared with only 2 percent of the births in cities (1 percent among white and 13 percent among Negro infants).

More than half (56 percent) of all the live births in the United States occurred in hospitals. Here again the proportion of hospitalized births was much higher in cities (84 percent) than in rural areas (25 percent), and for white infants (60 percent) than for Negro infants (25 percent).

The proportion of births in hospitals has increased considerably during the period of record. In 1935 (the first year for which information on attendant at birth was issued by the Bureau of the Census) 37 percent of the live births occurred in hospitals, compared with 56 percent in 1940. Births attended by physicians in homes dropped from 51 percent in 1935 to 35 percent in 1940. There was a decrease in the proportion of births attended by nonmedical persons from 12 percent in 1935 to 9 percent in 1940.

Table 9 presents the percentages of the births attended by physicians and by nonmedical persons in each State. The proportion of all births which occurred in hospitals varied widely. Thus, in the District of Columbia and in New York, Connecticut, Washington, California,

TABLE 9.—Attendant at birth in each State, 1940

State	Live births	Percent attended by—		
		Physician		Nonmedical person
		In hospital	In home	
United States.....	2,360,399	55.8	35.0	9.3
Alabama.....	62,925	29.5	46.9	32.5
Arizona.....	11,754	61.9	28.1	9.9
Arkansas.....	38,359	17.0	58.3	24.6
California.....	112,011	86.3	12.9	.8
Colorado.....	21,154	61.0	38.5	.5
Connecticut.....	25,195	90.8	8.7	.6
Delaware.....	4,597	69.0	20.8	10.3
District of Columbia.....	15,309	91.4	8.6	(1)
Florida.....	33,818	45.6	28.2	26.1
Georgia.....	64,998	28.6	36.2	35.2
Idaho.....	11,712	62.8	36.5	.7
Illinois.....	123,198	73.7	26.0	.4
Indiana.....	61,963	52.1	47.8	.1
Iowa.....	45,464	58.9	41.1	(1)
Kansas.....	28,695	52.6	47.2	.2
Kentucky.....	63,591	19.1	62.7	18.2
Louisiana.....	50,916	43.8	26.3	29.9
Maine.....	15,119	50.0	48.0	2.0
Maryland.....	30,251	58.4	34.3	7.3
Massachusetts.....	66,114	85.0	14.5	.5
Michigan.....	99,108	63.7	35.1	1.2
Minnesota.....	63,083	67.9	30.9	1.2
Mississippi.....	52,575	13.0	36.3	49.8
Missouri.....	62,172	47.8	47.5	4.6
Montana.....	11,492	81.0	17.3	1.8
Nebraska.....	22,162	53.4	46.6	(1)
Nevada.....	2,061	81.2	16.4	2.4
New Hampshire.....	8,503	74.5	25.4	.1
New Jersey.....	58,617	83.9	13.8	2.2
New Mexico.....	14,744	28.1	42.1	29.8
New York.....	196,888	87.0	12.3	.8
North Carolina.....	80,582	24.2	56.9	24.9
North Dakota.....	13,356	61.0	38.3	6.7
Ohio.....	114,900	62.4	37.5	.2
Oklahoma.....	44,574	39.7	55.4	4.9
Oregon.....	17,848	85.4	13.8	.8
Pennsylvania.....	165,680	62.0	37.6	.5
Rhode Island.....	10,805	77.2	21.8	1.0
South Carolina.....	44,380	18.9	37.6	43.5
South Dakota.....	11,619	55.8	45.4	.8
Tennessee.....	55,815	29.3	39.8	10.9
Texas.....	126,687	42.3	41.7	15.9
Utah.....	13,559	67.9	31.0	1.0
Vermont.....	6,694	55.0	44.9	.1
Virginia.....	55,208	28.1	46.8	24.1
Washington.....	28,141	86.6	13.2	.2
West Virginia.....	42,103	19.7	76.5	3.9
Wisconsin.....	54,818	64.0	35.6	.4
Wyoming.....	5,022	68.2	30.3	.5

¹ Less than 1/2 of 1 percent.

[Unpublished table supplied by courtesy of the U. S. Bureau of the Census.]

Massachusetts, Montana, Nevada, New Jersey, and Oregon, more than four-fifths of all the births occurred in hospitals and relatively few births were not attended by physicians. In Arkansas, Alabama, Kentucky, Mississippi, South Carolina, and West Virginia, on the other hand, less than one-fourth of the births occurred in hospitals and in all but West Virginia

a relatively large proportion of the infants were born without medical attention. In general the more densely populated States and the States with a smaller proportion of Negro births had a high ratio of hospitalization. In the more rural States and States with a relatively large Negro population, where the ratio of hospitalization was low, there was a high ratio of births with no medical attention. The proportion of births with no medical attention was 25 percent or higher in 9 States, and reached 50 percent in Mississippi.

SUMMARY

The downward trend in maternal and infant mortality of previous years continued through 1940. The maternal mortality rate (38) and the infant mortality rate (47) are both all-time low records.

The reduction in the maternal mortality rate for the 5-year period 1936-40 from the period 1931-35 was 27 percent. The reduction was largest for deaths from infection (31 percent). Considerable reduction occurred also in deaths from toxemias (24 percent) and from hemorrhage, trauma, or shock (16 percent).

The decrease in infant mortality rate in the 5-year period 1936-40 compared with 1931-35 was 12 percent. The decrease was more pronounced in mortality of infants 1 to 11 months of age (16 percent) than of infants under 1 month (10 percent). The decrease in maternal and infant mortality was equivalent to a saving of the lives of 18,550 mothers and of 80,901 infants.

There has been an increase in the proportion of live births that occurred in hospitals from 37 percent in 1935 to 56 percent in 1940. Births attended by physicians in homes decreased from 51 percent of all births in 1935 to 35 percent in 1940, and the proportion of births with no medical attendant decreased from 12 percent in 1935 to 9 percent in 1940. There are, however, many States in the country in which the maternal and infant mortality rates and the proportion of births attended by nonmedical persons are very much higher than in the country as a whole.

Oregon Organizes Its Health Services on Emergency Basis

The reorganization of the State Board of Health of Oregon to meet emergency conditions is described in the following letter from the State Health Officer to the Governor of Oregon:

OREGON STATE BOARD OF HEALTH,
PORTLAND

December 10, 1941.

HONORABLE CHARLES STRAGUE
Governor of Oregon
State Capitol
Salem, Oreg.

DEAR GOVERNOR: Effective immediately, for the duration of the emergency, this office and its staff are available on a twenty-four hour a day, seven days a week, basis to render service of any kind pertaining to the public health of the State of Oregon.

Plans previously outlined are now being put into effect, and the following definite steps have been taken:

1. All county and city health personnel is being advised that, effective immediately, they must be easily available by telephone or messenger, day and night.

2. All local health personnel is ordered to cooperate to the fullest extent with other defense agencies in the area in which they reside, and to prepare and maintain on a current basis, in writing, a complete report of that information which might be of value in an emergency. A copy of this report, with frequent additions thereto, is to be sent to the State Board of Health, where a complete State-wide file will be maintained of all of this information. The above file will have information concerning prevalence of communicable diseases in the local area, condition of water supply, milk supply, food supply, housing facilities, etc., with an analysis of the probable effect that could be anticipated from an epidemic of any disease resulting from bombing, fire, or flood. This file is, of course, to be available to Central Health Staff and other organized emergency defense agencies.

3. The staff of this office, each of them specialists in a specific public health field, will, on periodic visits to the various local health units, advise and consult with the local health personnel as to the procedure in time of emergency.

4. The personnel of the central public health staff is effective immediately on a *twenty-four hour, seven days per week*, basis, and may be reached by calling the State Board of Health, Oregon Building, Portland, Oreg., telephone ATwater 1388. Special arrangements are being made so that all calls for public health information or advice, or for special public health supplies and services will be routed through that number until the present emergency is past.

5. A team of well-qualified central staff members is available for transportation to any emergency area if

this becomes necessary, the team composed of various specially trained personnel as the need indicates. This mobile unit will have available the services of: (a) The State Health Officer and his professional assistants with their staffs; (b) A mobile unit equipped for emergency communicable disease work with self-contained laboratory; and (c) Mobile staff of engineering experts available in event of disaster to water supply. This unit is also equipped for milk and excreta sanitation work with emergency equipment for work in field.

6. A handbook of emergency public health measures is being compiled and will shortly be in the hands of all local and central public health personnel for use in the event of emergency. This booklet will include procedure outlines for prevention, immunization against, quarantine, isolation, and treatment of communicable disease, proper technique for emergency water-supply purification, excreta sterilization, decontamination, etc.

7. In addition to the above local and central organization, the plan is being worked out whereby the local health unit of any given area must hold itself in readiness on orders received through this office to move to the assistance of an area affected by epidemic or other disaster. Each unit has been advised to make provision so that the regular health service of the area may be taken over by a substitute staff in the event it is necessary to temporarily transfer the regular staff to another location to meet the emergency.

It is believed that with the above plan, the public health facilities of the State of Oregon will be capable of meeting any public health emergency which may arise.

Authorities of adjacent States are being advised of our plan, and are invited to participate in an interstate plan so that in the event of catastrophe in one State, the emergency resources of another State may be made available.

The specialized resources of the United States Public Health Service and the Children's Bureau in the Department of Labor are not being overlooked, and in the event of need, this office will promptly call for assistance by these Federal agencies.

It is respectfully suggested that various responsible authorities be advised of the public health preparedness program in this State, and

to direct any inquiries for information concerning the plan for consultation concerning public health problems, or for emergency public health personnel, equipment or supplies

to this office, 816 Oregon Building, Telephone ATwater 1388, Portland, Oreg.

Respectfully,

STATE HEALTH OFFICER.

BOOK NOTES

YOUR TEETH; their past, present, and possible future, by Peter J. Brekhus, D.D.S. University of Minnesota Press, Minneapolis, 1941. 255 pp. \$2.50.

Dr. Brekhus' thesis is that dental disease is due primarily to disuse of dental structures as a result of the methods of food preparation developed by civilized man.

Among all civilized peoples today caries is almost universal among the young, and pyorrhea among the middle-aged, states Dr. Brekhus. He reviews various alleged causes of these diseases but concludes that, while diet, dental hygiene, bacteria, systemic disease all play a role in the causation of dental disease, none alone can be considered the sole or even the predominant cause.

Not only is decay of teeth prevalent, but malocclusion and other structural abnormalities are common and are in increasing prevalence from generation to generation, according to Dr. Brekhus.

Dr. Brekhus describes the teeth of other races of man and also of animals and reiterates the point that the impact of civilization with its infrequent meals of cooked foodstuffs has produced a degeneration of teeth.

The volume concludes with a statement to the effect that dental disease is probably here to stay, since the possibility of inducing civilized man to revert to the coarse, uncooked food of primitive man is relatively remote and that, therefore, the best method of attack upon the problem is to realize that our general hygienic measures are ineffectual and that we must rely for our dental well-being upon early and constant repair of dental decay as it occurs. It is most important that caries in children be adequately treated.

The economic problems raised by such an admission of need are enormous. The author believes that only a very small proportion of the children of the United States can afford adequate dental care, so that if dental health of the country is to be maintained some form of large scale Government subsidy will be essential.

D. V. W.

STATURE AND WEIGHT OF CHILDREN OF THE UNITED STATES, by Howard V. Meredith, Ph.D. *American Journal of Diseases of Children*, Vol. 62, No. 5 (November 1941), pp. 909-932.

The influence of racial, regional, socioeconomic, and secular factors on the stature and weight of children as revealed in medical reports, is examined by the author who concludes that secular differences (differences due to time) covering the last 50 years are twice as great as any of the other differences considered, and

that the geographic differences are the smallest. He points out the need for additional studies in this field with the most rigorous possible control of extraneous factors in order to measure the differential effect of one item while holding the other three constant.

FROM INFANCY TO ADOLESCENCE, by Frieda Klefer Merry and Ralph Vickers Merry. Harper & Bros., New York, 1940. 330 pp. \$2.

Development, as discussed by the authors, covers a span of time from the first fetal movements to adolescence. Development throughout this period is continuous and many phases of growth occur simultaneously. For convenience of discussion the authors have divided their material into three age levels, (1) the prenatal and postnatal period extending roughly from the first fetal movements before birth through the first 2 weeks after birth, (2) infancy and the preschool period from the end of the first period to about the age of 6, and (3) the period from school entrance to adolescence, from about 6 to 12 years of age.

Within these age periods the authors have discussed the various phases of development, showing in all cases the gradual maturing of the growth patterns and the gradual growth from one age level to the next.

Motor development depends upon maturation and follows a definite sequence. Freedom for movements of all kinds and discriminating praise for achievements encourage the maximum motor development. Language is considered to begin with the birth cry and continues through an orderly sequence to adult speech. The rate of development of language varies considerably and has been shown to depend upon such things as intelligence, family background, and ability to hear. The authors discuss at some length intelligence, its measurement and the significance of measuring intelligence. How a child learns, what he learns, how fast he learns, and what he forgets are described. The development of emotional behavior and the development of play are each discussed. A chapter is devoted to graphic and musical expression. The child's reading is discussed both as to development of the mechanism for reading and as to development of the ability to understand what he reads. The impact of the radio and the motion picture on the child's development is considered. The last two chapters deal with personality and with character and religion.

D. V. W.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Working and Living Conditions on Connecticut Tobacco Plantations

By EDNA M. PURTELL

Industrial Investigator, Department of Labor and Factory Inspection, Hartford, Conn.

THE ANNUAL inspection of Connecticut tobacco plantations, made in August 1941 by the Connecticut Department of Labor and Factory Inspection and the Consumers' League of Massachusetts, disclosed such shocking conditions, particularly in the employment of extremely young children, that an aroused public demanded an immediate clean-up.

Although the Department has no jurisdiction over agricultural employment, its exposé made in 1932, of child labor, housing of seasonal workers and general conditions of employment on the State's tobacco fields, resulted in an agreement, signed by most of the large growers, not to hire children under 14 years of age. Since then annual inspection has been made by the Department and by the Consumers' League of Massachusetts. Through the co-operation of some growers in their effort to observe the agreement and of the State Board of Education in issuing certificates of age, the employment of children under 14 years had decreased and living and working conditions were gradually improving. The Department was unprepared, therefore, to find most of this slow progress swept away in 1941. Employment of children as young as 8 years, importation of child labor from as far south as Florida, overcrowding in substandard dwellings, unfit supervision, and hazardous transportation, all had returned.

Anticipating a shortage of adult labor because of the many defense industries in the northern part of the State where most of the

large plantations are located, the Connecticut State Employment Service, as early as March 1941, offered to cooperate with the growers in registering high-school and college students for work in the fields. A considerable number of students did register but, because of the lack of suitable housing, referral was not made of those living outside a convenient transportation area. For years the Department has pointed out the urgent need for adequate housing of migrant workers and has consistently made such recommendation to the growers.

There are approximately 55 growers of shade tobacco in the State. Twenty-seven fields, representing 16 growers, were inspected in 1941.

Child labor.—Although announcement was made as in the previous year in schools in the tobacco area that certificates of age would be issued for work in the fields, there was a discouraging drop in the number of applications. A sincere attempt to live up to the agreement was evident on 6 fields, but the attitude of the growers in general was that they were "too busy" to request proof of age or that an applicant who "looked under 14 years" was not hired. On 15 fields children 11 and 12 years of age were employed, and on 6 fields children 8 and 9 years of age were found working.

Approximately 1,200 children were transported daily in trucks owned and operated by the company from Ludlow, Chicopee, and Springfield, Mass. They were usually picked up at 5:45 in the morning and reached home about 7 at night. After a rainy spell, which

interrupts the work, the children were often picked up as early as 4:45 a. m. In at least two instances, youngsters were ordered from trucks miles from home to make their way back as best they could. In one case investigators found a group of small boys on a highway 7 miles from the point at which they had boarded the truck that morning. They were ordered off the fields when they refused to work until the ground had "burned off" after a night and early morning of rain. Two Springfield boys, 13 years of age, at quitting time, informed the truck driver of one large corporation that they would not return for work the following day. Claiming they were no longer employees, he refused to transport them home. The boys arrived home late that night after their distraught parents had sought police aid.

Forty-six boys, 14 to 21 years of age, were brought from Quincy, Fla., and Recovery, Ga., by one large corporation. The boys carried written statements of their parents, most of which merely gave permission for "my boy to go to Connecticut to work." One requested simply, "Please, send my boy back in time for school."

Labor force and supervision.—On the fields covered by inspection, approximately 3,000 men and 1,400 women and girls were employed. These included 438 male Negroes brought from the South for the season, 310 of whom were college students.

Because of the shortage of labor in the defense-industry area, supervision on some fields was at a low level. Drifters were recruited indiscriminately from cities and placed as straw bosses over boys in the fields and girls in the sheds. Department investigators were obliged to ask for the assistance of the State police on the fields of one large corporation when 20 boys, 10 to 15 years of age, accused a straw boss of making improper advances and constantly threatening them with a long-bladed knife. The boss, who fled at the appearance of police, was eventually apprehended, admitted the charges, and was sentenced to jail. His arrest disclosed a police record dating back to 1923. The superintendent on one large plantation ad-

mitted striking a 13-year-old boy with an iron hauling hook.

Wages.—An increase in wages over 1940 was general, undoubtedly because of the shortage of labor in the vicinity. In the sheds the daily rate for girls who counted and distributed leaves to the sewers was from \$2 to \$2.75, depending on age and experience. Sewers received 45 cents a bundle with some fields offering 5 cents extra per bundle if the worker remained to the end of the season. The average experienced worker sewed between 7 and 8 bundles a day. The younger boys engaged as pickers in the field received from \$2.35 to \$3 a day and the older boys and men, employed at hauling baskets of picked leaves from the tobacco rows to the trucks, from \$2.75 to \$3.25 a day. It was not unusual to find a boy of 12 earning \$3 daily.

Hours.—All fields were operating on a full 6-day week, a few on a 9-hour day and 54-hour week, the majority on a 9½-hour day and 57-hour week. On two fields a 10-hour day and 60-hour week was the schedule and after a rainy spell almost all worked a 10- to 10½-hour day.

Transportation.—Overcrowding of trucks, most of which were company owned and operated, was not uncommon, with workers from Massachusetts being forced to stand on the hour's journey home. Tailboards were often missing and a narrow chain substituted. There are no State regulations on the transportation of plantation workers if the truck is owned by the grower. An ordinary commercial license plate is all that is required. It is interesting to note here that buses used to carry some of these same children to school and privately owned cars transporting passengers for hire are subject to strict regulations, rigidly enforced by the Motor Vehicle Department and the Public Utilities Commission.

Sanitary conditions.—Because of an epidemic of trench mouth found in construction work, the State Department of Health in June issued a regulation requiring individual drinking cups for use of all outside workers. As a result paper cups were in use on 16 fields. On

7 fields, however, the common dipper was still in use.

Separate privies for men and women were found on nine fields, four had none at all, and on the remainder there was one privy for common use. Seven provided toilet tissue.

Living conditions.—Fifteen company-owned boarding houses, in which most of the migrant workers lived, were inspected. Eight were for white men and 7 for Negro men. With few exceptions these were ancient 2- or 3-story frame structures. Inside toilet and bathing facilities were usually lacking, and 1 or 2 outside privies and improvised showers often served as many as 60 men.

White boarders paid \$6.50 or \$7 a week for a room (usually shared with one or two others) and three meals a day. The boarding houses were as clean as the limited facilities would allow, and the meals appeared adequate and well served. A few white children were found rooming in company-owned private dwellings, but the old problem of large numbers of seasonal child boarders from Massachusetts and distant points in Connecticut was not present.

Negro boarders pooled food costs, which averaged weekly between \$3 and \$3.50 per man. In past years no charge was made for a bed. In 1941 the increase in earnings of 25 or 50 cents a day was offset in some cases by a charge of \$1.75 a week for a bed. In some boarding houses overcrowding was so serious that a man was forced literally to crawl over other beds to reach his own. Part of a tobacco shed, still in use, was converted into sleeping quarters by one grower.

The company-owned model boarding house for white men, built in 1938, was in excellent condition after 3 years of occupancy. Here were large, single rooms, clean and adequate

bedding, screened porches, comfortably furnished living rooms, tiled wash sinks, toilets and showers inside the building. The weekly board with three full meals a day was \$6.50.

Conclusions.—Immediately upon the publication by the Commissioner of Labor of the facts disclosed in the investigation of the tobacco fields, the chairman of the Connecticut Agricultural Defense Labor Committee called a meeting of the Connecticut Valley Shade Growers Association to which the Department was invited to send representatives. The attitude expressed by some growers at this meeting was not by any means encouraging. They denied the existence of some of the conditions reported and held that others were necessary in the nature of the industry. The association appointed a labor committee to meet with a committee from the Department of Labor and Factory Inspection to consider standards for the industry, but no meeting was called by the association.¹

For the past 8 years the Department has made every effort to alleviate working and living conditions on the State's tobacco plantations through voluntary cooperation with the growers, a few of whom have honestly endeavored to raise standards in the industry by self-regulation. The collapse of these persistent efforts in 1941 proves the necessity for legislative regulation similar to that to which Connecticut industry in general is subject.

The Department of Labor and Factory Inspection is recommending, therefore, enactment of a State law prohibiting the employment of any child under 14 years (the age limitation of the voluntary agreement) in highly industrialized agriculture.

¹ The Connecticut Valley Shade Growers Association dissolved in November 1941.

Child-Labor Standards in Sugar Act of 1937 Renewed

Under an act approved by the President on December 26, 1941, the provisions of the Sugar Act of 1937, including the labor standards with which producers of sugar beets or sugarcane must comply in order to receive benefit payments, are extended and continued for 3 additional years, that is, up to and including 1944. The labor standards set in the 1937 act included a prohibition of employment of children under 14 years of age and a maximum 8-hour day for children between 14 and 16 years of age. The immediate family of the legal owner of at least 40 percent of the crop at the time the work was performed was exempted from these child-labor provisions.

The 1941 act also carried over and extends through 1944 the amendment added to the act in 1940 providing that the Secretary of Agricul-

ture is authorized to make benefit payments with respect to any crop notwithstanding a grower's failure to comply with the child-labor provisions, but that there must be deducted from such payments \$10 for each child for each day or portion of a day during which such child was employed or permitted to work contrary to these provisions.

The 1941 act also increases the base rate of payment to producers of sugar beets and sugarcane from 60 cents to 80 cents per 100 pounds, the rate of 80 cents to be paid on the first 350 tons produced by any one producer. This rate is scaled downward for all production in excess of 350 tons. The benefit payments of the Sugar Act are also extended to the Virgin Islands.

Public Law 386, ch. 638, 77th Congress, 1st Session, H. R. 5988.

Extension of Federal Child-Labor Standards for Agriculture Proposed

A bill has been introduced in Congress by Senator Thomas of Utah for Senator LaFollette of Wisconsin for the purpose of enlarging and clarifying the application of the child-labor provisions of the Fair Labor Standards Act of 1938 to the employment of children in agriculture other than on their home farms. This bill (S. 2057) is now before the Senate Committee on Education and Labor.

Under the present law children employed in agriculture, during periods when they are not legally required to attend school, are expressly exempted from the child-labor provisions of the Fair Labor Standards Act. As a result of this exemption, the child-labor standards applying to employment in agriculture are made depend-

ent upon the application of State compulsory school attendance requirements. There is no coverage unless attendance is mandatory for the child in question.

S. 2057 proposes to eliminate this exemption, and to extend to children employed in agriculture, other than on the home farm, the same protection now afforded to children in other nonmanufacturing and nonmining occupations: That is, a minimum age standard of 16 years, except that children of 14 and 15 may be employed in agriculture, as in other nonmanufacturing and nonmining occupations, under regulations that will insure that the work will not interfere with their schooling, health, or well-being.

Policies Regarding the Employment of Mothers of Young Children in Occupations Essential to the National Defense

In this time of crisis it is important to remember that mothers of young children can make no finer contribution to the strength of the Nation and its vitality and effectiveness in the future than to assure their children the security of home, individual care, and affection. Except as a last resort, the Nation should not recruit for industrial production the services of women with such home responsibilities.

—FRANCES PERKINS,
Secretary of Labor.

* * * * *

The welfare of mothers and children should be given due consideration at every point in the development of employment policies relating to national defense. Although barriers against the employment of mothers with young children should not be tolerated, such mothers should not be actively recruited as a new source of labor for either training courses or employment until other sources of labor supply in the local community have been fully utilized. Where need is demonstrated for the employment of mothers with young children, or where in indi-

vidual cases mothers seek employment, they should be placed on shifts which will make it possible for them to discharge their responsibilities for the care of their children with such supplementation from community facilities for child care as may be necessary. Every effort should be made to avoid the employment of mothers with young children on the night shift.
—*Recommendation of the Conference of the Women's Bureau Advisory Committees, January 22, 1942.*

* * * * *

Proposals for the establishment of facilities for the 24-hour care of children or facilities operating 24 hours a day in caring for different groups of children should be weighed carefully. Where it is reported that such facilities are required in a community, it may indicate the need for careful examination of employment policies, community resources, and other related matters, to determine whether alternative plans cannot be developed for the proper care of children of mothers employed in occupations essential to national defense.

—KATHARINE F. LENROOT,
Chief, Children's Bureau.

The Grace Abbott Fellowship in Public-Welfare Administration, 1942-43

A public-welfare fellowship of \$1,000 for the academic year 1942-43 is offered by the National Delta Gamma Fraternity in honor of the public services of Grace Abbott.

This fellowship is open to any woman graduate of an accredited American college or university and may be used at any accredited school of social work, but it is restricted to candidates who have been employed in public-welfare service and who plan to return to the public service.

Applications should be filed not later than April 1, 1942. Any applicant who filed for the 1941-42 fellowship and who may wish to apply again should send for a second application form. Application blanks may be obtained from Mrs. Florence H. Blanchard, 2573 Van Dorn Street, Lincoln, Nebr., corresponding secretary of the committee that awards the fellowships.

World Federation of Education Associations

At a joint meeting of representatives of the Canadian Teachers Federation and of the American members of the Board of Directors of the World Federation of Education Associations, held in Montreal on October 25, 1941, it was voted by the representatives of the World Federation of Education Associations to accept the invitation of the Canadian Teachers Federation to hold a meeting in Montreal, Canada, July 8, 9, and 10, 1942. A local committee was

appointed to make plans for the entertainment of persons attending this meeting and to assist in preparing a program for the sections of the World Federation.

Announcement that it has been necessary to discontinue publication of *World Education* for the duration of the international crisis has also been received from the World Federation of Education Associations.

Washington release dated November 17, 1941.

Charlotte Whitton Resigns

The special year-end number of *Canadian Welfare*, published in Toronto by the Canadian Welfare Council, announces the resignation of Charlotte Whitton, for 15 years the Council's executive director. The inexhaustible and creative energy at Miss Whitton's command, the keenness of her intellect, and the depth and range of her interests, which reach back into the century and extend around the world, have found expression during her period of Council service in building a firm foundation for child

welfare throughout Canada. She has also contributed richly to public welfare in the United States and to the social work of the League of Nations. Throughout the world her colleagues value her courage and her practical wisdom. Fortunately, Miss Whitton is not retiring but is giving more fully than ever of her personality and her energy in interpreting for Canada and the United States the challenges which lie before us in the remaking of world relationships.

CHARLES E. GIBBONS

The sudden death of Charles E. Gibbons on January 1, 1942, means a serious loss not only to the National Child Labor Committee, with which Mr. Gibbons had been associated for 25 years, but to all organizations interested in child-welfare and to the cause of children throughout the country.

A resident of Cincinnati, Mr. Gibbons served as director of the employment bureau for that city early in his career and also cooperated in a study of child labor and school attendance in the State of Ohio.

After joining the staff of the National Child Labor Committee in December 1916, Mr. Gibbons made many field studies of child labor in various parts of the country and in 1926 became director of investigation for the committee. Moved always by compassion for the plight of children working at an early age, under dangerous or unhealthful conditions, or

at a sacrifice of education, he made his studies with a singleness of purpose and an uncompromising integrity that carried conviction to legislative bodies and to the public alike. For example, he brought first-hand knowledge of the exploitation of child workers in the sugar-beet fields to the sugar-stabilization hearings in Congress in 1934. His exposure of child labor in the Missouri tiff mines helped to arouse the public opinion that resulted in the adoption of a county child-welfare program in the tiff-mining area. A nearly completed report on children kept out of school to pick cotton and harvest other crops was interrupted by his death.

The memory Mr. Gibbons leaves with his many friends and coworkers is that of a gentle and courageous soul, sparing of others, unsparing of himself.

CONFERENCE CALENDAR

- | | | | |
|------------|--|-----------------|---|
| Feb. 19-21 | American Orthopsychiatric Association. Nineteenth annual meeting, Detroit. Chairman of Publicity Committee: Helen P. Langner, M. D., Vassar College, Poughkeepsie, N. Y. | Apr. 27-May 1 | National League of Women Voters. Biennial conference, Chicago. |
| Feb. 21-26 | American Association of School Administrators. San Francisco. | Apr. 30-May 1-2 | American Pediatric Society. Skytop, Pa. |
| Apr. 6-10 | Second American Congress on Obstetrics and Gynecology, St. Louis, Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago. | May 2-9 | Eighth Pan American Child Congress. Washington, D. C. |
| Apr. 6-10 | Association for Childhood Education. Golden jubilee, Buffalo, N. Y. Information from Association for Childhood Education, 1201 Sixteenth St., NW., Washington, D. C. | May 4-9 | National Congress of Parents and Teachers. San Antonio. |
| Apr. 7-9 | Eighth annual conference on the Conservation of Marriage and Family Life, at the University of North Carolina and Duke University. Information: Professor Ernest R. Groves, University of North Carolina, Chapel Hill, N. C. | May 5-8 | International Association of Public Employment Services. Louisville. |
| Apr. 10-11 | American Academy of Political and Social Science. Philadelphia. | May 6-8 | National Council of State and Local Welfare Administrators. New Orleans. |
| | | May 6-9 | National Tuberculosis Association. Philadelphia. |
| | | May 10-16 | National Conference of Social Work. New Orleans. |
| | | May 10-16 | National Probation Association. New Orleans. |
| | | May 18-23 | Biennial Conference of Nursing Organizations, Chicago. (National Organization for Public Health Nursing, American Nurses' Association, and League for Nursing Education.) |

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

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The

CHILD

*** Monthly Bulletin ***

Immunization Prevents Diphtheria and Smallpox

MAY DAY
CHILD
HEALTH
DAY -
1942

PERCENTAGE
OF CHILDREN
IMMUNIZED -

100%

90

80

70

60

50

40

30

20

10

0

IMMUNIZATION RECORD

of

Total Number of Children

Number Immunized
Against Diphtheria

Number Immunized
Against Smallpox

Total Number of
Immunizations.. ..

Date

BE WISE -
IMMUNIZE!

IMMUNIZATION DIVISION, DEPARTMENT OF SOCIAL CHILDREN'S BUREAU

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

MARCH 1942



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The President's proclamation calling for the observance of May 1, 1942, as Child Health Day is reproduced on the opposite page. Materials to aid in the preparation of May Day programs, which can be obtained from the Children's Bureau, include an immunization poster, 10 inches by 14 inches, in black and white (a small reproduction of this appears on the front cover), and a folder—Immunize All Children Before May 1—which contains the President's proclamation and a brief statement addressed to parents.

CHILD HEALTH DAY--1942

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health of children to the strength of the Nation, do hereby designate the first day of May of this year as Child Health Day.

And I call upon the people in each of our communities to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention.

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of the United States of America to be affixed.

DONE at the City of Washington this 6th day of February in the year of our Lord nineteen hundred and forty-two and of the Independence of the United States of America the one hundred and sixty-sixth.

By the President:



Secretary of State.



• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

The Youngest Workers in Three Urban Communities

By JANET H. LEWIS AND HELEN WOOD

Industrial Division, Children's Bureau

"What we do for our children *now* is going to determine not only the future of the United States, but the future of the world." Grace Abbott made this statement years ago but it applies with even greater force today. Children who will be the voters and statesmen of the post-war period and, as such, will be called upon to face the staggering problems of world reconstruction need every resource of knowledge and experience with which they can be equipped.

In any stock-taking of the educational and social equipment of youth, children who leave school under 16 years of age merit particular concern. These children have stopped their formal education before reaching the age generally regarded as the lowest at which it is desirable that children be permitted to leave school. Moreover, after quitting school they often spend long periods haphazardly looking for work or take low-paid jobs in unregulated occupations. The findings of a survey of children out of school, which was made in 1940 in three cities located in States where a minimum-age standard of 16 years for employment during school hours had not been achieved, clearly indicate the serious problems of these out-of-school children and the need to maintain and strengthen existing school-attendance and child-labor standards.

The survey was conducted in Elizabeth, N. J., Tulsa, Okla., and Richmond, Va. It was made by the Children's Bureau for the purpose of obtaining information about the number of boys

and girls in urban communities who were in the labor market, the extent to which they were securing jobs, and the character of the jobs open to them. This article presents preliminary findings with regard to the children under 16 years of age included in the survey. The study also covered boys and girls of 16 and 17 years; information pertaining to this age group will be presented in a future publication.¹

Elizabeth, Tulsa, and Richmond were selected as the scene of the study, because they are medium-sized cities (having populations of 100,00 to 200,000 according to the 1930 Census of Population), scattered as to geographic area and differing in racial composition and in the general character of their employment opportunities. The selection of cities was limited, moreover, to States where, at the time of the study, the basic, legal minimum age for employment during school hours, at least in nonmanufacturing industries, was lower than 16 years and where some full-time employment of children under 16 was therefore to be expected.² A final reason for the selection of these cities was that they could each put at the disposal of the Children's Bureau school and

¹ A preliminary report presenting some of the major findings for Elizabeth, N. J., was published by the Children's Bureau in 1941. This report, which is entitled "The Youngest Workers in an Urban Community; Elizabeth, N. J.," covers boys and girls of 16 and 17 years as well as those under 16 years of age.

² In June 1940, after the field work was completed in Elizabeth, a new child-labor law was enacted in New Jersey which established a minimum age of 16 for work in any occupation during school hours. This law became effective September 1, 1940.

community records which would provide the names, addresses, and dates of birth of all, or practically all, the boys and girls under 16 years of age who were not attending school.

Elizabeth is a highly industrialized city in the Northeast with a population in 1930 of 115,000, one-fourth of whom were foreign-born white persons and less than 5 percent of whom were Negroes. Tulsa, with a population of 141,000, is primarily a mercantile and trade center with a considerable number of its people engaged in servicing the oil industry. It is in the southwestern region of the United States, and its population is predominantly native white. Richmond, a State capital, is a semi-industrialized southeastern city with Negroes comprising nearly one-third of its population of 183,000.³

During the first 7 months of 1940 the Children's Bureau field agents called at the homes of 450 girls and boys under 16 years of age who were not enrolled in regular full-time day school and interviewed either the children themselves or responsible members of their families. Insofar as it was possible to tell, these children included approximately all those who were out of school in Elizabeth, Tulsa, and Richmond at the time of the study.⁴

Child-Labor and School-Attendance Standards.

Legal standards, their interpretation, and their enforcement are significant factors in determining the number of children who leave

school under 16 years of age. The wide variation in the size of the out-of-school group in the three cities surveyed is evidence of this. In Elizabeth, 35 girls and boys under 16 were found to be out of school; in Tulsa, 158; in Richmond, 257. Although Tulsa and Richmond are somewhat larger cities than Elizabeth, they are not enough larger to account for these differences in the numbers of out-of-school children. Instead, the relative sizes of the groups can be attributed largely to differences in the provisions and enforcement of the school-attendance and child-labor laws.

In Elizabeth there was effective enforcement of closely dovetailed school-attendance and child-labor laws. In New Jersey at the time of the survey, all children between the ages of 7 and 16 years were required to attend school full-time unless they were 14 years of age and had completed the eighth grade (or were 15 years of age and had completed the sixth grade), had been granted age-and-schooling certificates, and were regularly and lawfully employed.⁵ Moreover, under the child-labor law, children could be employed in non-agricultural pursuits only if they were at least 14,⁶ had employment certificates, and attended continuation school. The strength of the New Jersey laws lay to a considerable extent in these last two requirements. The certificate system made possible administrative knowledge and control of children leaving school under 16 years of age and the requirement of continuation-school attendance tended to discourage the hiring of children under 16.

In Tulsa, where the number of working children was considerably larger than in Elizabeth, the child-labor law is not dovetailed with the good compulsory-school-attendance law. Under the Oklahoma school-attendance law, no child may leave school for employment until he is 16 years of age. On the other hand, un-

³ These are 1930 Census of Population figures. The 1940 census figures were not available at the time the survey was made. Releases issued subsequently by the U. S. Bureau of the Census show, however, that between 1930 and 1940 the population of Tulsa did not change substantially; that Richmond's population increased slightly; that Elizabeth's decreased slightly.

⁴ The public-school authorities in Elizabeth said they knew of a very few additional children (a total of 20 under 18 years of age) who were confined to their homes because of mental or physical handicaps. These children were not interviewed because it was thought that there was no reasonable likelihood of their being in the labor market. Otherwise, the survey covered all the children under 16 known to be out of school in Elizabeth as of January 10, 1940, in Tulsa as of May 3, 1940, and in Richmond as of the school census made during April and May 1940. The primary sources of the children's names and addresses were public and parochial elementary and secondary school records and school-census records.

⁵ Children mentally and physically incapacitated are exempted from school attendance in New Jersey, as they are also in Oklahoma and Virginia.

⁶ Children 10 years of age or over desiring to support themselves or their families were permitted to work, outside school hours only, in selling newspapers, running errands, and doing some similar types of work, if they obtained "age and working certificates."

der the State child-labor law, passed much earlier, there is a minimum age of 14 for employment, applying only to factories, factory workshops, and a few other types of establishments. Moreover, provision is made in the child-labor law for the issuance of age and schooling certificates for children under 16 years of age. As early as 1924 State labor and education officials and certain local school officials, concerned over the inconsistency between these laws, adopted forms of employment certificates designed "to conform to the provisions of the compulsory-school-attendance law, the part-time school law, and the child-labor law." It was apparently the intention of the officials who initiated this arrangement that the standard of the school law should be the one enforced and that children under 16 should not be permitted to leave school for employment. However, the standard actually adhered to in particular localities depends upon the interpretation given the two laws by local school officials responsible for the issuance of certificates.

The particularly large number of children under 16 at work in Richmond is attributable mainly to certain provisions of the Virginia school-attendance law. Children in this State are not required to attend school after they become 15 and may leave at an earlier age if they have completed the elementary course of study⁷ and are regularly and lawfully employed. The State child-labor law sets a 14-year minimum age for nonagricultural employment. It also provides for the issuance of employment certificates to children up to 16 years. However, these certificates do not serve as an adequate control over children's entrance into employment in the absence of a requirement that they attend school up to 16 years of age, at least when not employed on employment certificates.

The three cities surveyed thus differed considerably in their legislative controls over the work of children, as well as in their geographic, industrial, and racial situations. The findings as to the children's reasons for leaving school

and the nature of their jobs are presented for the three cities together with occasional notations of marked differences from city to city.

Children Not in the Labor Force.

Some children who leave school under 16 at once go to work or begin looking for work. Others stay at home for reasons such as illness, or their families' need to have them help with household duties. As table 1 shows, 191 of the 450 out-of-school children in the study were neither working nor looking for work outside their homes at the time of interview.

TABLE 1.—*Employment status of children under 16 years of age not enrolled in full-time school in Elizabeth, Tulsa, and Richmond*

Employment status	Total	Elizabeth	Tulsa	Richmond
Total	450	35	158	257
In the labor force	259	27	79	153
Employed	127	23	35	69
Unemployed	132	4	44	84
Previously employed full time	49	3	17	29
Not previously employed full time	83	1	27	55
Not in the labor force	191	8	79	104
Because of mental or physical handicap	80	1	22	57
Because of temporary illness	39	3	30	6
Because of household duties	35	4	14	17
For other reasons	37	—	13	24

According to the statements made by their parents, 80 (42 percent) of these 191 boys and girls were mentally or physically handicapped or were suffering from prolonged illnesses which, in many instances, would preclude them from ever attending regular full-time school. Another 20 percent were at home temporarily because of operations, accidents, and remediable illnesses such as influenza and tonsillitis. The parents of many of this latter group expected them to return to school in the fall of 1940. The remaining 38 percent were out of school for reasons other than health. They were for the most part 13-, 14-, and 15-year-old girls who were needed at home to help with household

⁷ In Richmond, according to the superintendent of schools, this requirement is interpreted to mean completion of the seventh grade.

duties. However, some of the children had simply lost interest in school, and a very few were not attending because of the expense entailed. The group who were out of school because of lack of interest in school work consisted mainly of 15-year-old Richmond children who had taken advantage of their legal right to leave school.

Children in the Labor Force—Their Economic Background.

Of the 450 children interviewed 259 were either working or looking for work and had therefore become part of the labor force of the Nation.⁸ These 259 children appeared to have been influenced considerably in their decision to leave school by their families' economic and social situation. Of those who reported their reasons for leaving school almost one-half said that their families' income was not sufficient to allow them to continue, or gave reasons such as need "to help at home," or "to go to work," which also suggest some economic stringency at home. One-third of the 259 children had left because they were unable to make a satisfactory adjustment to school.

It was obvious to the Children's Bureau interviewers that, in each of the cities, most of these children came from the lowest economic groups in the population. In Elizabeth their homes were for the most part in ramshackle and dilapidated dwellings crowded in the waterfront area. In Tulsa many of them lived in the poverty-stricken sections of the city and in the shack towns on the "city dumps." In Richmond they were often found in the flimsy, insanitary houses of the poorest white and Negro workers. Of the 176 children who were working or who were unemployed but had had at least 1 full-time job, 38 percent came from families which had received either direct or work relief or both during the year preceding the study. Comparable data were not obtained for the 83 unemployed children who had never had a full-time job, but their economic and social background was probably much the same

as that of the children for whom detailed information is available.

A large proportion of the working children came from broken families. Of the 176 boys and girls who either were working or had had full-time work experience, only half were living in homes where both parents were present. The other half lived, in some instances, with their fathers only or with relatives but most often with their mothers only. This high proportion of broken families not only handicapped the children from an economic point of view but may well have been a factor in their unsatisfactory adjustment to school.

The father was the chief wage earner in only a little more than half of the children's families. In the other families either there was no father in the home or the father was unable to work, with the result that someone else was forced to assume primary responsibility for the family's support. In 29 percent of the children's families the mother was the chief wage earner and in another 16 percent the chief wage earner was a brother, a sister, a relative, or even the child himself. Three percent of the families had no chief wage earner and depended customarily on relief or public assistance.

Unemployment of the chief wage earner was a major factor in the economic difficulties of many of the children's families. Only 69 percent of the 176 children were members of families where there was a chief wage earner who was employed. Moreover, the usual occupations of the chief wage earners were in most cases at the lower end of the economic scale and were of types which are not very remunerative even when the worker is employed full-time. In view of these circumstances it is not surprising that one-third of the children said that they had left school because of insufficient income in their families and that nearly three-fourths of them contributed all or part of their earnings to their families.

Children in the Labor Force—Their Education and Job Opportunities.

What were the general employment characteristics of the boys and girls who had entered the labor market at so early an age? To what

⁸The term labor force is here used, as in the 1940 census, to include inexperienced as well as experienced workers.

extent had their education equipped them for earning a living? Could their employment experience be regarded as an adequate substitute for further education?

Girls were outnumbered by boys among the 259 children who were in the labor market. A substantial minority (41 percent) of the 259 children were Negro. The great majority (86 percent) were 15; some were 14 (12 percent); and a very few, living in Tulsa and Richmond, were 12 or 13 years of age (2 percent).

Completion of eight grades in school is little enough educational preparation for earning a living and for citizenship under present-day conditions. Yet even using an eighth-grade education as the minimum standard, the children in this study were found to be greatly handicapped. Almost half of the 259 children who were working or looking for work had completed 6 grades or less^a and one-fourth had completed no more than the seventh grade. In other words, little more than 25 percent of the children had obtained a basic eighth-grade education.

TABLE 2—*Employment status of children under 16 years of age in the labor force, by sex*

Employment status	Total		Boys		Girls	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total.....	259	100.0	146	100.0	113	100.0
Employed.....	127	49.0	80	54.8	47	41.6
Full time.....	85	32.8	50	34.3	35	31.0
Part time.....	42	16.2	30	20.5	12	10.6
Unemployed.....	132	51.0	66	45.2	66	58.4
Previously employed full time.....	49	18.9	30	20.5	19	16.8
Not previously em- ployed full time.....	83	32.1	36	24.7	47	41.6

These young boys and girls, who were unlikely to secure much additional schooling, were at the same time in an unenviable position as members of the labor force. Forty-five percent of the boys and 58 percent of the girls were without a job of any sort (table 2). Further-

more, more than one-third of the employed boys and one-fourth of the employed girls were in part-time jobs of less than 30 hours a week. Of the out-of-school group who were unemployed and wanted work, few had had employment experience of any consequence. One hundred and thirty-two of the 259 children in the labor market were unemployed, and of these little more than one-third had had a job since leaving school on which they had worked as much as 30 hours in any week. The Negro girls had been the least successful in the labor market, from the point of view both of the proportion who were unemployed and of the proportion of the unemployed who had never had full-time work experience.

Employed Children—Their Jobs and Working Conditions.

Detailed information is available with regard to the jobs held by the 127 girls and boys who were employed at the time of the interview. For the most part friends helped these children to get their jobs. Others of the children, however, secured their jobs by making a personal application or because their employers knew them or their families and asked them to come to work. In Elizabeth and Tulsa a few of the children worked for their parents; in Richmond, a few were self-employed as boot-blacks or newsboys. Only 1 child reported that he had obtained his job through an employment office, although there were public employment services in each of the three cities.

With few exceptions the girls were working in domestic-service occupations, most often as general houseworkers but sometimes as nurse-maids or mothers' helpers. Among the 10 girls who were not household employees, there were several salesgirls, a laundry worker, a packer, and 2 waitresses. Messenger and delivery work, mainly for retail drug and grocery stores, was the boys' most frequent source of employment, accounting for 38 percent of their jobs. Another 18 percent of the boys were in service occupations such as caddying, shoe shining, waiting on table, and sweeping and cleaning of retail shops. Fifteen percent held sales jobs as hucksters, hucksters' helpers, or newsboys.

^a Children who left school from ungraded and special classes were included in this group.

It is immediately evident that these occupations required little previous training and afforded meager opportunity for the development of skills or for future increases in earning capacity. Certain of the jobs also involved working conditions of undesirable types. Seven of the 37 girls who were household employees lived at their employers' homes. The bicycle-delivery boys, of whom there were 15 in Tulsa and Richmond, were in jobs likely to involve considerable danger as a result of heavy traffic in the streets. Also, 7 of the boys were employed as truck drivers' helpers and 1 as a truck driver, occupations determined by the Chief of the Children's Bureau to be particularly hazardous for young people up to the age of 18 years under the Fair Labor Standards Act of 1938.¹⁰

Wholesale and retail trade and personal services were the industries that provided 80 percent of the children's jobs. Others of the boys and girls worked for amusement concerns, bakeries, restaurants, and local trucking companies. Less than half a dozen were employed by manufacturing concerns shipping their products in interstate commerce, a type of employment for which there is in general a 16-year minimum age under the child-labor provisions of the Fair Labor Standards Act of 1938. The young people whose experience this study reports were, therefore, working in most instances in intrastate employment outside the coverage of Federal wage, hour, and child-labor standards and subject only to State regulation of working conditions.

On the whole, the boys and girls worked long hours and received low wages. Half of the children reported 40 or more hours of work a week; a fourth of them, 50 or more hours a week. Nine out of ten children with part-time jobs and almost half of those with full-

time jobs¹¹ earned less than \$5 a week in cash wages.¹² These long working hours and low weekly wages together resulted in very low hourly earnings. Two out of five of the employed children are estimated, on the basis of the weekly hours and earnings reported, to have made less than 10 cents an hour, and more than four out of five, less than 20 cents an hour.

The household employees were the largest single occupational group among these employed children, and included 37 of the 47 girls and 3 of the 80 boys. Half of the 40 household employees reported 36 or more hours of work a week. Six of them worked more than 60 hours a week. Despite these long working hours, half of the 40 children earned less than \$4 a week in money wages. On the other hand, 32 of them received either room and board or one or more meals a day in addition to their cash wages.

In messenger and delivery service, which employed more of the boys than did any other single occupation, the working hours were even longer than in household employment. Half of the 30 boys with messenger or delivery jobs worked more than 48 hours a week, and 6 worked more than 60 hours. More than one-third of them earned less than \$4 a week in cash wages; more than one-half earned less than 10 cents an hour. Furthermore, many of these boys were subject to the considerable expense of buying a bicycle and keeping it in repair.

Children's Jobs in Relation to Child-Labor Standards.

The protection of children against work at too early an age in intrastate jobs, such as domestic service and delivery work for retail stores, is dependent upon State legislation. Under the existing legal standards in the three States, much progress has been made in keeping boys and girls in school and out of the labor market up to 16 years of age. However, in Virginia children are not required to attend

¹⁰ Hazardous Occupations Order No. 2, issued by the Chief of the Children's Bureau under the child-labor provisions of the Fair Labor Standards Act of 1938, declares the occupations of driver and helper on a motor vehicle to be particularly hazardous for minors between 16 and 18 years of age. This order, which was effective January 1, 1940, has the effect of applying to these occupations the 18-year minimum age standard of the act. However, its legal applicability is limited to employment in or about establishments producing goods for shipment in interstate commerce.

¹¹ For the purpose of this survey part-time employment was defined as less than 30 hours work a week; full-time employment, as 30 or more hours a week.

¹² Eight children received no cash wage. Most of them worked for their parents.

school beyond their fifteenth birthday, and therefore many children leave school at 15. In addition, a considerable number of Tulsa and Richmond children had left school for work at a younger age than was permissible under the school-attendance laws.

Although the legislation governing hours of employment had undoubtedly had considerable influence on children's working hours in the cities visited, it was evident that the existence of legal standards does not of itself achieve these standards for all children. In Elizabeth 8 of the 23 employed children reported working more than the maximum of 42 hours a week then set by the New Jersey child-labor law for children attending continuation school. In Richmond 29 of the 68 children reporting their hours of employment said they worked more than the 44 hours legally permissible. And in Tulsa 8 of the 29 children in jobs other than domestic service reported a work week in excess of the legal maximum of 48 hours. Domestic-service workers in Oklahoma, as in many other States, are specifically excluded from the maximum-hours provisions of the State child-labor law. For the adequate control of child-labor conditions in domestic service, where many of the young workers were employed, there is need to extend the protection of the child-labor laws to children in this occupation.

The extensive and careful issuance of employment certificates does much to prevent children below the minimum age from leaving school and furnishes some control over the working conditions of those legally employable, by calling the attention of employers to child-labor standards and by assisting the inspection authorities in locating working children. It is no mere coincidence that, of the three cities visited, Elizabeth, with the fewest boys and girls under 16 in the labor market and the fewest children reporting excessively long hours of work, had the most thorough enforcement of the employment-certificate system. All but 3 of the 23 employed children interviewed in Elizabeth had employment certificates. In Richmond, on the other hand, only 3 out of 69 children had obtained certificates as required

by law. Of the 35 employed children under 16 years of age who were interviewed in Tulsa, 11 had employment certificates, but under the Oklahoma compulsory-school-attendance law children may not leave school for work under 16. The inconsistency of this situation illustrates the need to eliminate gaps between child-labor and school-attendance standards.

Conclusion.

The problem which this study reveals is one of too early curtailment of schooling, of employment of children in substandard jobs which form an inadequate substitute for continued education. Most of the children under 16 in the labor market in Elizabeth, Tulsa, and Richmond left school before completing the eighth grade. Most of them were able to obtain work only in occupations, such as delivery work and domestic service, which are unskilled and poorly paid and which hold little promise of future advancement.

Improvement in legislative standards with regard to school attendance and child labor and in the enforcement of these standards would help to insure for children the basic education required for intelligent citizenship, but it would not fully solve the problem. As this study indicates, many children leave school for work because their families are too poor to provide them with adequate clothes or have positive need of their small wages. As a result of the war program, an upswing in employment is now under way which will undoubtedly relieve this situation to some extent by reducing the number of unemployed breadwinners. However, it will not appreciably affect problems arising from the death or permanent disablement of a child's father, nor those from a wide range of other causes. If school-attendance and child-labor laws are to be effective, further progress toward an adequate wage level in all occupations and toward the extension of economic security through other means will be necessary. In addition, scholarship aid will be needed in many families with low incomes or heavy financial responsibilities, to enable children to stay in school.

Policies on Recruitment of Young Workers for Wartime Agriculture

The Problem

As this year's crops ripen many young people not now living on farms may be called upon to help with the harvest. It therefore becomes a matter of great urgency to determine proper standards and procedures to protect them from exploitation, from overwork, from interference with their education, and with their rights as children of a democracy. Properly managed, the experience can become an educational one, contributing to the young person's appreciation of what democracy means, because it gives him a part in the effort democracy is making. Badly managed, it can damage the health and stamina of children, deprive them of needed preparation for life, and cruelly disillusion them. Badly managed, it can also break down opportunities for decent wages and full employment for their elders.

The necessity to produce abundant foodstuffs during this war period is a challenge to the Nation to utilize its resources of manpower

with intelligence and forethought; and the Bureau, facing this challenge, has realized that definite standards should be established to serve as a guide to people throughout the United States in determining at what ages young people may properly be asked to engage in work on the crops, and under what conditions.

It is important that the development of national policy and standards on the use of young people in agricultural work in wartime recognize the interests of (1) those concerned with education, (2) those concerned with protection of children from exploitation, and (3) those concerned with meeting agricultural labor needs. With this in view the Children's Bureau invited into conference representatives of the Office of Education, the Department of Agriculture, and the United States Employment Service and, with their cooperation, prepared the following statement of principles for the recruitment of young workers for agricultural employment.

Statement of Policy

Prepared in Conference With Representatives of the Office of Education, the Department of Agriculture, and the U. S. Employment Service, and Approved by These Agencies

As the Nation's all-out war effort progresses, it may be necessary in some areas to recruit young people not ordinarily in the agricultural labor force for assistance in harvesting the crops. In all such cases their recruitment for agricultural work needs to be so planned as to assure safeguards for their health and welfare and to protect them from unnecessary interference with their education. Policies for the employment of young workers should be developed with full regard to laws on child labor and school attendance and to safeguards neces-

sary to protect the health and well-being of these young workers and the continuity of their education. Specifically, the recruitment of young workers for agriculture should be planned and conducted in accordance with procedures providing that—

All plans for the use of young workers are developed as part of broad programs for meeting the needs of agricultural labor based on consideration of all available sources of labor and the wages and working conditions offered to adults;

State departments or agencies dealing with education, labor, health, and agriculture participate in the

development of policies regarding recruitment of young workers and possible modification of school programs, and in the application of these policies to local situations;

Proposals for employment of young workers during normal school terms are approved only after the Farm Placement Service of the United States Employment Service for the several States determines, on the basis of full information on the labor situation, that the anticipated need for labor cannot be filled by older persons resident in the locality or reasonably available from outside the locality.

In recruiting young people from school when a real need for agricultural workers has been found to exist—

Youth 16 years of age and older should be engaged before children aged 14 and 15 are called upon; the schools should make every effort to develop programs that will wisely dovetail school activities with agricultural work and will result in no curtailment of school terms;

Children 14 and 15 years of age should not be released from school nor their school programs modified unless it is found that the need for farm labor is an essential one and cannot be met in any other practicable way; in such case

adjustment in school attendance and programs should be arranged to interfere as little as possible with normal school opportunities and progress.

School work and home duties should constitute the only work activities of children under 14 years of age; and such children should not be employed in agriculture outside the home farm.

When young workers are placed in agricultural work, provision should be made for safeguarding their health and welfare through reasonable hours of work; wages at not less than established prevailing rates; safe and suitable transportation where needed; and, for those living away from home to be near their work, provision of fully adequate housing accommodations, supervision, medical care, and leisure-time activities.

This statement of national policy is made in the belief that the principles presented are essential for safeguarding children, are fully compatible with the needs of wartime production, and will facilitate the constructive participation of youth in the Nation's great productive effort.

Children's Bureau Commission on Children in Wartime

Members of a Children's Bureau Commission on Children in Wartime have recently been appointed by the Chief of the Children's Bureau with the approval of the Secretary of Labor. The group is broadly representative of national organizations concerned with children and has a nucleus made up of the chairmen of the Children's Bureau advisory committees and State and local officials responsible for services to children.

The commission will convene March 16, 17, and 18, 1942, to consider measures urgently needed for the protection and welfare of children in emergency situations arising as a result of the outbreak of the war. On the agenda for the 3 days' sessions are discussions of problems of protection for children in case of enemy attack; measures for safeguarding health and

well-being of children in war production centers; methods of dealing with wartime psychological problems of children and with juvenile delinquency; the maintenance of school opportunities and child-labor standards in the face of pressures upon boys and girls to abandon their schooling for factory work, service jobs, or work on farms; and the care of children whose mothers join the industrial labor force.

Representatives of the Office of Civilian Defense, the Office of Defense Health and Welfare Services, the Social Security Board, the Office of Education, the Public Health Service, the Extension Service and the Bureau of Home Economics of the Department of Agriculture, and the Work Projects Administration have been asked to meet with the commission as Government advisers.

• **BIRTH** •

• **GROWTH** •

• **CHILD HEALTH** •

Mortality From Premature Birth in the United States

Data in regard to mortality from premature birth obtained from death certificates are made available to the United States Bureau of the Census, where certain tabulations are made. From this information the Children's Bureau has prepared charts for the use of those interested in prematurity as a public-health problem.

The accompanying charts have been prepared from the most recent data available.¹

Chart 1 shows that among the causes of infant death prenatal and natal causes, including premature birth, play the chief role, accounting

for 58 percent of the deaths of infants under 1 year of age in 1940.

Among the causes of neonatal death (deaths of infants under 1 month of age) premature birth plays the chief role, accounting for 46 percent of these deaths in 1940. It can be seen from chart 2 that 84 percent of the neonatal deaths were due to prenatal and natal causes,

Chart 1.—CAUSES OF INFANT DEATH; PERCENTAGE DISTRIBUTION, 1940.

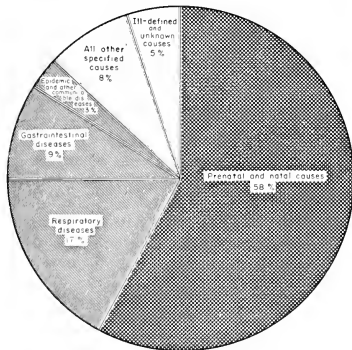
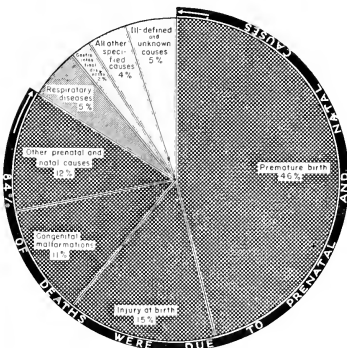


Chart 2.—CAUSES OF NEONATAL DEATH; PERCENTAGE DISTRIBUTION, 1940.



Deaths assigned to injury at birth and congenital malformation, including deaths of premature infants from these causes, accounted for 15 and 11 percent, respectively, of the neonatal deaths in 1940.

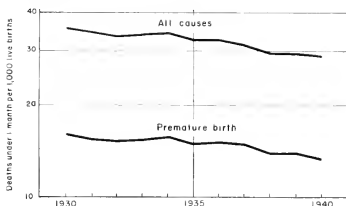
The mortality rate of infants under 1 month whose deaths were attributed to premature

¹ All data used in this article and in the charts are based on reports from the U. S. Bureau of the Census.

birth was 13.3 per 1,000 live births in 1940 in the United States and ranged from 9.1 to 18.0 in the various States.

During the last decade the trend of neonatal mortality from premature birth has shown a gradual decline from a rate of 16.0 per 1,000 live births in 1930 to 13.3 in 1940 (chart 3). The rate for 1940 showed only a slight decrease compared with that for 1939. The decrease for the entire period is 17 percent compared with a decrease of 28 percent in the total infant mortality rate in the same period.

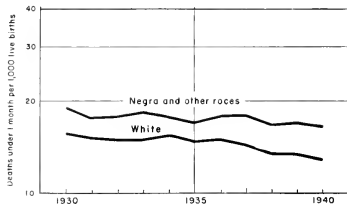
Chart 3.—TREND OF NEONATAL MORTALITY FROM ALL CAUSES AND FROM PREMATURE BIRTH, 1930-40.



The neonatal mortality rate from premature birth among infants of nonwhite races was higher than among white infants (chart 4), and this relationship has been consistently maintained in the period 1930-40. The trend of the mortality rate for Negro infants and infants of other nonwhite races has shown in the past 10 years a gradual decline, but the decrease has been relatively less than that for white infants.

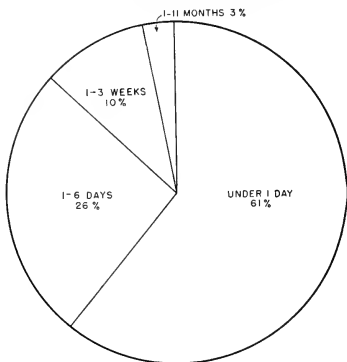
Chart 5 shows that the largest proportion (61 percent) of deaths among infants who died from premature birth occurred on the first day of life and that about one-fourth (26 percent) of the deaths occurred from the second to the

Chart 4.—TREND OF NEONATAL MORTALITY FROM PREMATURE BIRTH, BY RACE, UNITED STATES EXPANDING BIRTH-REGISTRATION AREA, 1930-40.



sixth day. In the remainder of the neonatal period—the second, third, and fourth weeks—10 percent of the deaths occurred. The remaining 3 percent of the deaths occurred after the end of the neonatal period but before the end of the first year of life.

Chart 5.—AGE AT DEATH OF INFANTS THAT DIED FROM PREMATURE BIRTH, 1940.



Plan for Hospital Unit for Premature Infants

By ETHEL C. DUNHAM, M. D., AND OLIVIA FOUNTAIN TESONE AND SILVER L. TESONE, *Architects*,
Washington, D. C.

It is generally agreed that individualized care is a protection to the health of the infant in the neonatal period. The ideal plan would be to have each infant under the care of a physician, preferably a pediatrician, tended by a qualified nurse, in a separate unit of space properly equipped for such care. The nearer the ideal is reached, the greater the chances of a normal neonatal period for the infant.

The standards for care of newborn infants require that in addition to individualized care adequate space be provided; that in this space the optimal conditions of temperature, humidity, and ventilation prevail; that protection from infection be afforded; that provision be made for qualified medical and nursing personnel; and finally that the infant's nutritional needs be met in such a way that growth and development are optimal.

The plan outlined here deals only with provision of adequate space for each infant. It has been devised to assist hospital authorities in planning construction of units for newborn full-term and premature infants in new hospitals or in remodeled hospitals.

Each unit of space is arranged to house four premature infants, the maximum number of such infants that, according to the standards published by the Children's Bureau,¹ can be cared for satisfactorily by one nurse. Two of these units constitute one unit for eight full-term infants—the maximum number of such infants that can be cared for satisfactorily by one nurse.

Each unit planned for the individualized care of four premature infants should be at

least 13 feet long, 10 feet wide, and 9 feet high. A unit of this size provides approximately 300 cubic feet of air per infant, an amount which meets the recommended standard of 200 to 400 cubic feet² for a unit that does not have air-conditioning with forced ventilation. This unit provides also adequate floor space for four bassinets or incubators which measure approximately 2 feet 6 inches by 1 foot 4 inches; for an allowance of at least 6 inches of space around three sides of each bassinet and an aisle space of 2 feet between bassinets; for two disposal cans about 1 foot in diameter; for a table about 2 feet by 1 foot 3 inches; and for a lavatory about 1 foot 6 inches square.

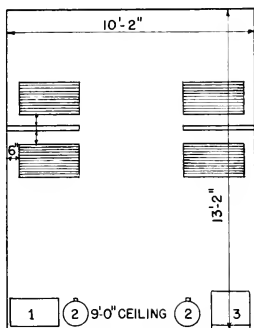
The figure on page 230 shows a unit for four premature infants with the bassinets arranged in four positions, in any one of which they meet the standard for space in that the bassinet stands at least 6 inches from the wall and there is at least 2 feet of aisle space.

In unit A the bassinets are arranged at the sides of the unit with glass partitions separating them to form cubicles. The bassinets are placed 6 inches from adjacent walls and from the sides of the cubicles, and there is space of at least 2 feet on the sides away from the walls. In unit B the cubicles are placed centrally. In unit C and unit D the bassinets are arranged without cubicles to give more than the required amount of space between bassinets.

This plan does not include the accessory rooms needed for the care of newborn and premature infants, such as an isolation room, a supply room, a utility room, and a milk room.

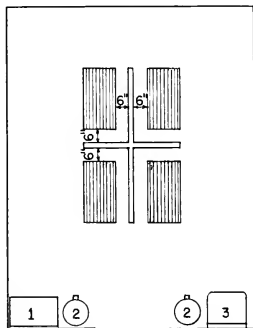
¹Standards for Care of Premature Infants in Hospitals Having a Maternity Service. Children's Bureau, Washington. 8 pp. Mimeographed.

²Manual on Obstetric Practice in Hospitals. American Hospital Association, Chicago. 1940. 96 pp.

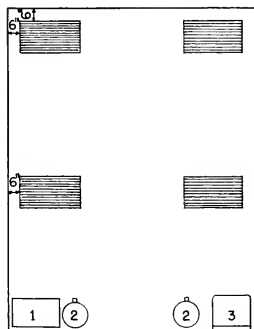


UNIT A

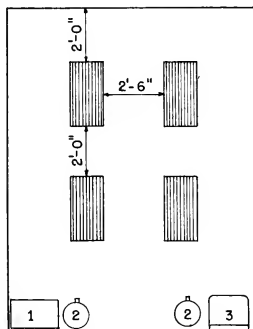
- KEY
 1. TABLE
 2. DISPOSAL CAN
 3. LAVATORY



UNIT B



UNIT C



UNIT D

EACH UNIT CONTAINS 134 SQ. FT. 1206 CU. FT. — 301 CU. FT.
 OF AIR PER INFANT WHEN OCCUPIED BY FOUR INFANTS

HOSPITAL UNITS FOR PREMATURE INFANTS

DEFENSE NOTES

Children's Workers in the Nation's War Effort

Let no one whose daily job is concerned with safeguarding the health and welfare of children feel that he or she is not contributing to the war effort of the Nation.

Our first aim in war must be to defeat the enemy, our next to save and protect our children. Every physician, every public-health nurse, every medical-social worker, who helps to make maternity safe and childhood a period of health and growth, every child-welfare worker who helps parents, teachers, judges, and recreation leaders to see that children are saved from neglect and delinquency, is giving a service which is supremely important in time of war.

— KATHARINE F. LENROOT.

Emergency Steps at the University of California

Six steps have been taken by the Department of Nursing at the University of California which illustrate some of the ways in which a university can prepare for emergency service. In brief they are as follows:

1. An extra group of 50 student nurses were admitted in January. An additional instructor and

assistant have been appointed, and shifts have been made in the curriculum to enable this group of students to graduate 7 months ahead of the usual time.

2. Courses in home nursing for women students at the university have been worked out with the American Red Cross, which will share the expense entailed with the university. The university has employed a nurse instructor for this work.

3. Courses for volunteer nurses' aides are being offered in cooperation with the American Red Cross and the Office of Civilian Defense. Students will get ward practice at the university hospital, the Cowell Hospital, or the Berkeley General Hospital. The university has employed a nurse instructor for these courses.

4. A course in first aid is being given for the graduate nurses on the campus by a graduate nurse instructor who is a member of the faculty of the School of Nursing. In addition the university is offering a first-aid course to the university employees who are not on the professional staff.

5. The clinic of the university hospital has been designated as a first-aid station and relief center. Graduate nurses in the hospital have been assigned for emergency work at the center.

6. The demonstration room at the university hospital will be freed for possible use as an emergency ward during the spring term. It has been equipped for the occupancy of about 30 patients.

BOOK NOTES

THE ROLE OF THE TEACHER IN HEALTH EDUCATION, by Ruth M. Strang, Ph.D., and Dean F. Smiley, M.D. Macmillan Co., New York, 1941. 350 pp.

Although this book was written for the classroom teacher, it contains much of interest to administrators having responsibility for planning school-health programs and for doctors and nurses who have a part in school-health education.

In the chapters on foundations of health education, prevalent health problems, and the health program as a whole, the authors bring the reader up to date in present-day philosophy and practice in the field. Other chapters deal with the more technical aspects of teaching methods.

Each chapter contains a list of references.

* * *

ANNUAL REPORT, National Society for Crippled Children of the United States of America, Inc., July 1, 1940—August 31, 1941. 27 pp. Mimeographed.

BOARD OF HEALTH, TERRITORY OF HAWAII, BUREAU OF VITAL STATISTICS, REPORT FOR FISCAL YEAR 1940. 163 pp. Mimeographed. This report contains a brief résumé of the activities of the Bureau of Vital Statistics and detailed statistical tables on mortality in Hawaii, tabulated according to causes of death, race and sex, major geographical divisions, and months of occurrence.

NEW PERIODICAL

Dental Health is the title of a new quarterly bulletin published by the National Dental Hygiene Association (334 Shoreham Building, Washington, D. C.) with Randolph G. Bishop as editor. The leading article "Dental Health Needs," in the issue for February 1942 (Vol. 1, No. 1), is by Lt. Comdr. C. Raymond Wells, Chief Dental Officer, Medical Division, National Headquarters, Selective Service System.

The National Dental Hygiene Association was established in June 1940 by the Martha M. Hall Foundation as a nonprofit-sharing corporation for the advancement of dental health.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

Clinical Psychology in the Idaho Child-Welfare Program

BY EDITH A. DAVIS, PH.D.

Consulting Psychologist, Idaho Child Welfare Services, Boise, Idaho

Psychological services for children were first made available for the use of Idaho child-welfare workers in 1939. Until that time there had been no systematic psychometric examination by a qualified clinician of the children served by public or private agencies, although occasionally a child was tested before commitment to an institution by a local educator with a background in psychology. Since this was done without remuneration in addition to duties already heavy it could obviously be only a makeshift arrangement with none of the possibilities of long-term study and repeated examinations.

The nearest approach to clinical study in Idaho developed, as was natural, in Moscow, seat of the State University of Idaho. A similar group has recently been formed in Idaho Falls. In addition, Dr. Mary Calloway, staff physician at the State School and Colony, had undertaken a survey of the population of that institution for mentally deficient persons, making a rough classification that was of immediate practical value.

In 1939 the request of the superintendent of the Nampa State School and Colony for psychological services was met through the child-welfare services under the Social Security Act, which financed the work for 2 months. During this period the fact was unearthed that an appreciable percentage of the persons committed without psychometric examination were not feeble-minded. The highest intelligence quotient at Nampa (111) was found in a woman 50 years of age who had been in residence for

21 years.¹ Almost simultaneously Bice published findings of a similar nature based on a study made in Kentucky.²

The nonfeeble-minded individuals in the institution were usually poorly adjusted adults or dependent children who had been committed on the basis of family history or because of personality or physical characteristics that made them unpromising for adoption. A number of these normal or borderline children and young adults were selected for foster-home placement.

During the past 2 years about a dozen of these normal or borderline children and young adults have been placed in foster homes or at the National Youth Administration Institute under child-welfare supervision. With one exception the youngsters have made good both in academic and vocational training and in social adjustment. The dullest of the group, a pretty girl of 16 who had been committed in infancy, was placed in the home of a woman who managed a school for beauty operators, in the expectation that she would learn techniques of professional hair dressing, for which she had shown aptitude while in the institution. After a few months it was found necessary to discontinue the experiment because of her general inability to adjust.

¹ Revised Stanford-Binet, form L.

² Bice, H. V.: A Study of an Institution Population Where Commitments Are Made Without Psychological Examination. American Association on Mental Deficiency. Proceedings and Addresses of the Sixty-third Annual Session, 1939. *Journal of Psycho-Aesthetics*, vol. 44, pp. 259-263.

The period of residence in an institution has naturally left a mark on every one of these young people. Some are inarticulate and lacking in initiative. Several have needed detailed supervision in personal hygiene. Unexpected problems connected with spending money, the interplay of normal family relationships, the emotional effects of school retardation, are constantly arising to challenge the ingenuity of the child-welfare worker, the foster parents, and school officials. Youngsters say, "I wish I was going into the ninth grade instead of the seventh,"—"I wish I was 10 years old and not so tall,"—"It makes you feel bad to be behind where you ought to be in school."

On the other hand, the writer has been frankly amazed at the ease with which these youngsters have made the transition from constant regimentation to comparative self-direction in an American home. Many of them have reported for follow-up examinations at unfamiliar places, and several have been entertained at meals in the presence of strangers. Comments from disinterested observers have always been favorable, both in regard to personal appearance and general behavior.

Thus, Philip, whose teachers think he can do 4 years of high-school work in 3 years, ranked fourth in a State-wide airplane-model contest; his older brother, after 18 months of training in animal husbandry at the Weiser National Youth Administration Institute, has already refused an excellent position, because his instructors think he should finish his course; Raymond was elected president of his ninth-grade home room; Ethel played a difficult piano duet for her eighth-grade graduation exercises; Mabel is making good in domestic service; and several have formed warm and probably enduring ties with the families in which they were placed.

After the initial period of work at Nampa, arrangements were made through child-welfare services to make psychological services available where requested throughout the State on a part-time basis. Short trips by the psychologist were arranged to counties where child-welfare workers were stationed. Workers met with school officials and other agencies in selecting children for examination. Usually a few talks before women's clubs, men's service organizations, groups of nurses, and parent-teacher associations were arranged. The staff

members of the local public-welfare office were called together to discuss the functions of psychological services in the case-work program. Nearly every school superintendent wished a short talk given for his teachers, and sometimes a practical talk on individual differences and vocational choices was given to the high-school students, or to college classes. However, it has seemed wise to limit such talks in the future to professional groups, or meetings of policy-forming organizations, in order to devote most of the available time of the psychologist to direct examination of children.

This work is helping to coordinate policies throughout the State toward problems that have not been handled with uniformity even in schools in the same city. The confusion is a natural consequence of Idaho's immense territory, sparse population, and topography. Some areas are virtually isolated during much of the year by impassable roads. The country school, to which children walk or ride horseback for miles over roads that no motor vehicle can traverse, is the only means of education for thousands of children, unless they live away from their homes. Teachers often have an enrollment of only 6 or 8 or 10 pupils.

Even in the largest cities there are no public-school kindergartens, and there is no provision for midyear promotion. A child enters school in September of the year when he becomes 6 years of age. If for any reason he is prevented from enrolling at the start of the school year or if he impresses the teacher as too immature for first-grade work, he must wait until the next September. A very large number of children in Idaho, therefore, are retarded 1 year or more from the very start. This condition is complicated by irregular school attendance due to transportation difficulties, illness, inadequate clothing, or change of residence. Under these circumstances a hot-lunch program is much appreciated and usually results in improved attendance.

Although the teacher understands these conditions, it is often difficult for her to accept as normal a child whose school entrance has been thus belated. "He didn't start school at all till

he was 8 years old—just lived out in the hills with the goats,” said a teacher of one boy, who was thereafter referred to, with a smile, as “the goat boy.” When this initial retardation is complicated by frequent changes of school and irregular attendance, social maladjustment is almost certain to develop, and the child is likely to be considered dull. If, in addition to all this, a child has a speech handicap, defective sight or hearing, lefthandedness, or a specific reading disability, the best that can be hoped for from the average teacher is tolerance and kindness toward a child classified as ineducable.

Some misconception was found among teachers and school officials as to the time required for individual psychological testing. Accustomed to group tests timed by the clock and scored by a key, teachers handed in long lists of children, with the expectation that behavior and personality difficulties of long standing could be ironed out as if by magic. It was necessary, therefore, for the child-welfare worker to discuss these lists with school officials, selecting cases which presented a definite problem and in which follow-up work was possible. Usually a simple referral sheet was then worked out, giving pertinent information and a statement of the specific problem involved. Sometimes a sudden development precipitated an unscheduled case into the program, but the extra effort entailed in handling such a problem has usually paid big dividends in increased appreciation and cordiality of the officials concerned.

Since it is undesirable for children or communities to associate mental testing with feeble-mindedness, and since teachers are inclined to refer only subnormal pupils and children presenting behavior problems, an effort is made to examine some of the brightest children as well as the handicapped.

The question of parents' consent to testing is always raised. School authorities differ on the necessity of obtaining parents' consent, but as a rule the best results have been obtained when interpretation is made in advance to both child and family.

An eighth grade boy from a family long known to child-welfare and public-assistance agencies had been involved in a series of petty delinquencies and truancy.

Before the child-welfare worker had time to pave the way, the probation officer went to the home and escorted Howard to school and thence to the examining room. The examiner, who did not know that the boy had been threatened with being sent to the reformatory, failed to reassure him, and the next day the boy disappeared, going to relatives outside the State. In all probability this outcome could have been avoided if the child-welfare worker had had the usual opportunity for interpretation.

Many teachers asked for interviews with the psychologist to discuss the findings of the examination and their immediate application to the child's problems. If a number of children had been drawn from a single school, a staff meeting for this purpose was arranged. Sometimes a series of small meetings were held to discuss changes in curriculum or administrative handling. Requests of parents for appointments were never refused by the psychologist, yet it is believed that as a rule it is satisfactory for the child-welfare worker to interpret findings and recommendations to the families, with whom they have already established a relationship.

The most satisfactory method of handling reports has proved to be a dual system. Test booklets and record sheets, together with the original of the full report, are kept in the State office of the child-welfare services in Boise; a carbon copy is sent to the worker; a second copy is supplied to the superintendent of any interested State institution or cooperating service; and a general summary, omitting “mental ages” and “intelligence quotients” but often including suggestions for educational procedures, is sent to the school. This statement can be shown to parents if they are inclined to question the decision in regard to promotion or curriculum and is often a valuable means of self-protection to a local school official.

The omission of a numerical intelligence quotient lessens the danger of the child's being given a permanent label, perhaps on the basis of a single, not-too-reliable test. Rather than risk having a brilliant child referred to in the community as “Little 140,” the examiner prefers to say: “This child is as far above the average as an imbecile is below the average,”

or "We find about three children in a thousand with this degree of ability."

During the second year of this program the demand for psychological services increased. There were more child-welfare workers in the field, and greater familiarity with the work rendered educators and other officials more receptive. Smoother handling of details and a generally improved relationship were apparent. Thus, a previous tendency of some educators who had had courses in mental testing to consider the work superfluous, if not a reflection on their own capacity, seemed to have disappeared. The superiority of individual testing and the value of the objective opinion of a stranger to the community, who was dealing constantly with children presenting problems, had apparently been demonstrated. At any rate, the cordial reception the examiner met with on returning to the counties previously visited was especially gratifying.

The success of this program is not hard to understand. Teachers were helped by suggestions concerning educational problems, and parents accepted the opinion of a stranger as unprejudiced. A simple statement to the effect that a child should continue to attend school for purposes of social contact is valuable to teachers constantly exposed to criticism, on the one hand, that they are failing to make the exceptional child normal and, on the other hand, that retaining him in school is a detriment to the progress of normal children.

Conversely, the teacher's point of view, if confirmed by test findings, could often be interpreted to parents. Especially when it was necessary to retain in the first grade children who after a whole year of attendance were barely ready to begin elementary kindergarten work were such firm statements found to carry weight. Parents must be led gradually to final acceptance of the finding that deafness alone does not account for their child's retardation, and that the attempt to educate children in lower grades of feeble-mindedness through the academic school classroom may not be wise. Often the hope has been only a glimmer, and parents are actually more nearly ready to consider commitment than has been suspected.

Because of the examiner's former residence in the State institution, it has sometimes been possible to broach the subject, even though such a step had been judged premature by child-welfare worker or nurse. First-hand information from one familiar with conditions there, and the knowledge that the mother may accompany the child and the person who conveys him on the trip and see for herself the efficient care provided, will sometimes bring about the decision.

There is wide variation in attitudes and procedures of teachers who encounter an exceptional child. In a small country school a teacher may gain years of experience without seeing a feeble-minded child or one who is unable to learn to read. When an exceptional child does appear, she has no techniques to meet the situation, although her "problem" pupil might offer no difficulties to the teacher in another district. Sometimes she honestly believes that she is not employed to teach a child who is "different" and asks the parents to remove him because his presence is detrimental to other pupils, or because he cannot learn by the regular methods.

One little girl, who had an intelligence quotient of 95 and a reading disability, rode her horse 6 miles morning and night to attend a school of six pupils, yet that teacher was unable to help her.

Another woman, confronted in the classroom with three brothers of dull-normal intelligence who had severe speech handicaps, could not be convinced that these boys, who made up one-third of her enrollment, were entitled to one-third of her time and could be helped to become self-respecting farmers like their father.

Some teachers, on the other hand, have handled these problems with initiative and competence.

Miss P kept feeble-minded Tommy in the primary room of a two-room school for 4 years. His speech improved, he learned to copy and draw a little and to recognize a few words, and his relationships on the playground were excellent. It is unlikely that his family will ever need to resort to his commitment to the State School and Colony.

Mr. White found that Chester had been retained in the lower grades year after year because of his reading disability, although he had no difficulty with arithmetic and took his place with his proper age group in play activities. This young principal devoted many evenings last year to drilling the boy in phonics.

"It doesn't matter," said the principal of a grade school in one of the larger towns, who was managing to provide individual instruction for a subnormal boy, "whether William is classified as in the first grade or in the fourth. He will continue to read at his proper level, which is the pre-primer."

Administrative problems involving exceptional children worry teachers. Is Bobby feeble-minded? Can he be taught by ordinary methods, if they are continued long enough? Shall I keep him in the first grade year after year, or will he respond better to another teacher? Is he better off in a room with children of his own size, even though the work is beyond his ability? What justification is there for promotions at the high-school age for the purpose of assisting in the child's social development? To what extent can the school system recognize and allow for individual differences in ability? When is a specialized curriculum feasible? What about the the gifted child?

In some junior high schools subnormal pupils were attending regular academic classes where they accomplished literally nothing; in other communities those below borderline mentality were rarely promoted beyond the sixth grade. One large town has started a special class in the junior high school. The program of psychological services has been of real assistance in working toward uniform handling of this present-day problem.

Many teachers were eager for suggestions as to methods and as to literature that would help them. Parents' criticisms ("the teacher pays no attention to Jeanie"—"the year Frankie did go to school they kept him penned in behind the organ, away from the other children"—"we finally took Albert out because he wasn't learning anything and the other children tormented him") were useful in explaining that a subnormal child can be nearly normal socially; that even a child in the imbecile range will grieve if slighted in little ways; and that a child who is not ready to learn to read is nevertheless greatly in need of the preliminary training in spoken language, motor skills, and group activities easily given in the schoolroom and woefully lacking in the underprivileged home—in

short, that academic instruction is not the sole purpose of the public schools.

The child-welfare-service files contain a valuable nucleus of information on subnormal children not in need of commitment. Crippled and paralytic children needing home instruction have been listed in readiness for the time when this service is available. Children presenting behavior problems are being followed over a period of years. Attention has been directed to a sprinkling of brilliant youngsters, some of them with poor socioeconomic background, who show such promise that plans for their advanced education should be formulated before they finish high school.

One of the child-welfare workers happens to be a highly trained and exceptionally able specialist in speech correction. She has held clinics in centrally located communities over most of the State, looking toward the beginning of speech work in the public schools. So far as possible children referred to speech clinics were also given psychometric tests, preferably before going to the clinic. Sometimes the feasibility of speech correction depends on the child's mental level. Again, valuable insight as to the source of the difficulty and needed remedial steps may be gained. As a result of the speech clinics, the outlook for a program of speech correction is distinctly hopeful.

Requests for examinations and consultations have been received from practically every Idaho agency. Physicians in private practice or school officials sometimes suggest examinations independently of child-welfare services. These are handled as private cases if the parents are able to pay a small fee. One or two school boards paid such fees before the connection with child-welfare services was completely worked out, and county officials have offered to do so for cases pending commitment. The Salvation Army Maternity Home has referred some cases. Crippled children's services, the Division of Public Health, the Vocational Rehabilitation Division, the State Industrial Training School, and the Mental Hospital at Orofino all have requested to have individuals examined. A few days each year are spent

(Continued on page 246)

NEWS NOTES

Letter From England

I started my job the last week in August, and am employed by the Mental Health Emergency Committee as a psychiatric social worker. The Committee is a body composed of the Child Guidance Council, the Central Association for Mental Welfare, the National Council for Mental Hygiene, and the Association of Psychiatric Social Workers. It was formed to meet the needs of the war, and the appointment of a representative and case worker in each civil-defense region is designed to meet the probable needs of the future as well as of the present, since it seems likely that the regional organization for local government purposes will supersede the old smaller units. Anyway we hope that the Committee's representatives will become a permanent part of the health services of the country. There is an ever-increasing demand for psychiatric social work both in the reception areas and in the evacuation areas, and the supply is not equal to the demand. Here we need two more workers, and the Ministry of Health has sanctioned their appointment, but we cannot get them as there are not enough trained people. So my case load gets heavier and heavier, and my appeals to the petroleum officer for more petrol more distracted.

We have an office car, but are only able to use it for journeys that simply can't be done by bus and train. Many of the friends I knew when I was here before have left and others have moved further out into the country, which is nice for weekends! Otherwise I am really too busy to bother about social life, and everyone else is too, what with fire-watching and voluntary A. R. P. or canteen work in addition to one's own job. And the blackout does not encourage going out for pleasure in the evenings, especially as the last buses and trains now leave about 9:45 p. m. Concerts are on Saturday afternoons, and theaters, lectures, and so forth, begin about 5:30 or 6 p. m.

I am finding the work quite enchanting, though at times quite exasperating because the facilities one needs in the way of clinics and psychiatrists are just not there. . . . Many of the children referred as "problems" are not neurotic at all, but just upset by the upheaval of evacuation, lack of their mothers and of familiar surroundings. Sometimes, too, there is the added complication of a whole different social custom—city children live in a different social "idiom," as it were, from those of the agricultural districts. And distinctions as to what is "wild" and therefore common property in the country are hard to learn. Hence the juvenile courts have been busy with minor offenses against property which are really nothing but misunderstandings.

Of course there are a good many deeply disturbed children who have not only physical symptoms such

as bed-wetting, but psychological ones such as anti-social behavior, destructiveness, lying, puffing and aggressiveness. Then my job is to try to adjust the situation so that the child feels reassured by having someone coming to see him specially each week, and the billet mother feels less anxious and gets to understand more of what the symptoms mean. If one can persuade her to give a bed-wetter special loving and attention instead of scoldings one can often get startling cures.

But there is often nothing to be done but to rehabilitate, and that means long talks with billeting officers, persuading them that the worst children need most cherishing, not as they would have it, the reverse! I do feel for the billeting officers, and admire them; I just wish they didn't have such a desire to dump a "difficult" child in the nearest hostel, irrespective of whether he is in need of special treatment or not!

We have one hostel in the region where we give psychiatric treatment, and there is a specially trained staff (two of them Austrian Jewish refugees and exceedingly good). And that hostel is enough for the children under eleven. We urgently need one for the older boys who are becoming a real problem for lack of suitable outlets for their growing energies.

The other hostels for difficult children are rapidly improving, and many of them have been supplied with the most necessary play material by the British War Relief Society of America. We usually help the matron to make the application, so as to get play material that will have real therapeutic value, such as sand trays, plastecine, and constructional toys.

In addition to the work among evacuees, there is the more general work of the Committee—endeavoring to get child-guidance clinics started in the bigger centers, trying to get mental hospitals to appoint psychiatric social workers, helping probation officers to run courses of lectures on delinquency and modern psychological methods, and making every effort to interest the justices in the whole subject of clinical treatment of delinquency. I myself am particularly interested in juvenile delinquency, and am delighted to find the probation officers very forthcoming.

My other special concern is the adolescent in industry, and of course in a heavily industrialized district such as this there is any amount of work. We get cases referred by the Ministry of Labour as well as by welfare workers and public-health officials, and cooperate closely with the Ministry of Health.

Although we are not a statutory committee, all the work done and our salaries, are paid for by a treasury grant—a recognition by the Government of the importance of the work—and, we hope, an earnest that it will consider the permanently constructive aspects of the work, and continue it after the war.

I do feel very much encouraged when I realize that it is possible to go on helping to create peace within the hearts of children and adults who are suffering from the effects of war, even while that war gets more agonizing daily. I am convinced that our work will have permanently constructive results, and it is being done all over the country.

NOTE.—This letter was sent to a personal friend, who has consented to its publication. The writer was trained first as a teacher, then as a social worker, and later in psychiatric social work. She did social work in factories for several years and then was one of His Majesty's factory inspectors.

Resolution on Child-Welfare Services

The National Council of State Public Assistance and Welfare Administrators of the American Public Welfare Association adopted on December 12, 1941, the following resolution presented by the Children's Committee:

Whereas the Children's Committee of the National Council of State Public Assistance and Welfare Administrators recognizes the importance of having special services for children available through State and local public-welfare units; and

Whereas it believes it is important to have increased Federal planning, leadership, and participation in the costs of providing complete coverage of child-welfare services to the end that these services shall be on a continuing rather than on a demonstration basis; and

Whereas the expanding defense program has pointed up the usefulness of the child-welfare services in meeting the problems of children, both immediate and anticipated, created or intensified by the existence of a state of war:

Therefore be it resolved, That the Children's Committee recommend that:

(a) The members of the Council give such support and leadership to national efforts directed toward providing more adequate public social services for children as may be consistent with their respective positions in the individual States; and

(b) The Council recommends to the Board of Directors of the American Public Welfare Association expression of continued interest in the expansion of children's services through State and local public-welfare organizations cooperating with the United States Children's Bureau under title 5 of the Social Security Act, since the expansion of established public services for children offers the best means of coping with additional responsibilities growing out of present and post-war conditions.

This resolution has also been incorporated in the minutes of the American Public Welfare Association.

Annual Report and Recommendations

Activities of the Children's Bureau during the fiscal year ended June 30, 1941, are reported by the Chief of the Bureau with recommendations as a part of the Twenty-ninth Annual Report of the Secretary of Labor (Washington, 1942, 165 pp.).

Special activities reported by the Children's Bureau include planning for emergency needs of children and young people, cooperation in inter-American child-welfare work, and cooperation in the care of European children seeking refuge in the United States.

The Children's Bureau report also describes the work of each division of the Bureau, including the several research divisions and the divisions administering the maternal and child health and welfare provisions of the Social Security Act and the child-labor provisions of the Fair Labor Standards Act.

The recommendations of the Chief of the Children's Bureau are as follows:

A democratic society has no power to survive unless its children are born and reared under conditions which make for strong, intelligent, resourceful, and devoted citizens.

Responsible parenthood is the first requisite in the nurture and training of children. But the degree to which childhood is safe and happy is also dependent upon the conditions of community living and the community services which are available to supplement home care. During this period when the resources of the Nation are being mobilized for total defense of all that we hold dear, the following steps should be taken in order to make sure that children everywhere in the United States receive the protection and service which their safety, health, and well-being require:

1. By local communities.—

a. Development of coordinated planning and action for children, with the participation of both public and private health and welfare agencies and citizens' groups and with stimulation from local councils of defense, councils of social agencies, or other resources for community leadership.

b. Direction of volunteer effort to reinforce professional staff in various fields of service to children.

c. Continuous effort to provide—

(i) Complete maternity care for all mothers who cannot obtain such care through their own resources.

(ii) Continuous health supervision for all children.

(iii) Medical, surgical, and dental care as needed for children of all ages.

(iv) Protective foods needed for good nutrition, at home and through school lunch programs.

(v) Adequate programs of general relief and aid to dependent children.

(vi) Social service to help conserve home life, prevent delinquency, and deal with problems of home and school relationships.

(vii) Adequate facilities and personnel for schooling and for recreation.

2. By the States.—

a. Full consideration by State Councils of Defense of the needs of children, and development of coordinated action necessary to assure their safety and well-being, in which the official agencies of the State and citizens' groups would participate. In achieving this objective the Council of Defense may work through a subcommittee on children, a State organization for follow-up of the recommendations of the White House Conference on Children in a Democracy, or some other appropriate organization in which official State agencies are represented or a citizens' group working in cooperation with official agencies. In some States a State-wide conference for the purpose of planning for the needs of children in relation to the defense program may be desirable.

b. Maintenance, and strengthening where needed, of State services to local units of government and of direct State services, where appropriate, for promoting the safety, health, and well-being of children.

c. Special consideration of measures to meet new or intensified problems of child welfare, utilizing existing agencies where possible. Examples of such problems are:

(i) Strengthening, where necessary, and full enforcement of compulsory-school-attendance and child-labor laws.

(ii) Services for the protection, care, and training of children and young people subjected to influences leading to juvenile delinquency.

(iii) Development of facilities for a varied program of leisure-time interests and pursuits adapted to the needs of children and youth.

(iv) Providing proper care and supervision for children of working mothers.

(v) Assuring the safety of children in case of external attack.

3. By the Federal Government.—

a. Action required to make sure that the needs of children receive full consideration in all fields of defense planning.

b. Increased appropriations to the Children's Bureau for:

(i) Advisory and consultation service to State agencies as to methods by which the special needs of children in defense communities and the general needs of children everywhere may be met more fully.

(ii) Full enforcement of the child-labor provisions of the Fair Labor Standards Act, under procedures assuring full cooperation with the Wage and Hour Division, and consultation service to State and local agencies to promote the maintenance and strengthening of child-labor standards.

c. Provision of Federal aid to State agencies of health and welfare to enable them to develop needed local resources for services to mothers and children in defense areas.

d. Extension throughout the Nation of essential community services for maternal and child health, crippled children, and child welfare through amendment to title V of the Social Security Act.

BOOK NOTES

PSYCHIATRIC SOCIAL WORK, by Lois Meredith French. Commonwealth Fund, New York, 1940. 344 pp. \$2.25.

This volume presents the results of a study of psychiatric social work sponsored by the American Association of Psychiatric Social Workers. It defines psychiatric social work as social work practiced in relation to psychiatry and discusses fully its current functioning in the two specific areas in which it is practiced, (1) Social work practiced within organizations—hospitals and clinics—concerned with treatment and prevention of mental disease and (2) mental-hygiene education in agencies where the worker fills a specialized role. Recognition is given to the fact that many members of the American Association of Psychiatric Social Workers are functioning elsewhere in the field of social work such as in family and child-welfare agencies, but this is regarded not as an extension of psychiatric social work but as a growth within

the general case-work field resulting directly from the increasing permeation of psychiatric knowledge.

The origin and development of psychiatric social work are carefully traced, and a statistical analysis is offered of the growth of the field in relation to numbers of workers, their professional equipment, salaries paid, and types of agencies represented. A survey is also made of the resources for professional education in the field. The development of professional courses in schools of social work is described, and the present requirements are discussed.

The chapter on trends in social treatment traces the changing emphasis in thinking and practice of the psychiatric social-work group from the period of emphasis on interviewing techniques through the developing interest in the dynamics of case-work relationships and the experimentation with various types of therapy.

An appendix gives a history of the American Association of Psychiatric Social Workers. There is a

bibliography of books and articles relating specifically to the field of psychiatric social work.

R. D.

CASE WORK SERVICE FOR UNMARRIED MOTHERS, by Ruth F. Brenner. Reprint from *The Family* (Family Welfare Association of America, 122 East Twenty-second Street, New York). 1941. 16 pp. 20 cents.

This is a report of a seminar participated in by the members of the staff of the St. Louis Children's Aid Society and St. Louis Provident Association and led by their consulting psychiatrist, Dr. E. Van Norman Emery. Approximately 100 current situations involving the treatment of unmarried mothers were discussed in a 2-year seminar.

The emotional aspects of work with the unmarried mother are presented. Of first importance is the relationship which the case worker establishes with the girl. This is often difficult since so many unmarried mothers have experienced unsatisfying relationships to their own families and particularly to their mothers. A relationship between the social worker and the girl can be more easily established early in the pregnancy when the unmarried mother is in need of concrete assistance and help in planning. The seminar emphasized the importance of focusing case work on the needs of the mother rather than on the earlier concept of the needs of the child.

Many of the mothers came from homes where in their opinion they had not had the love to which they were entitled—a fact which raises serious question about the placement of the baby in the mother's parental home. It was found, however, that the less love the mother had in her own home the more likely she was to insist on keeping the baby. Eleven points are suggested as criteria for evaluating the mother's interest in her child.

Unmarried motherhood, regardless of whether the mother keeps the child or places him in adoption, involves emotional shock, and it is therefore suggested that case-work treatment in most instances should continue for a 2-year period.

The seminar attempted to register impressions and to indicate the need for further studies rather than to draw final conclusions.

Clinical Psychology

(Continued from page 236)

at the Nampa School and Colony, checking on old cases and examining new ones. Religious schools and orphanages have referred children. The director of parent-education programs has expressed the desire to cooperate in interpreting findings to parents as well as in suggesting that they make use of the service. Supervisors and

FIRST COMPREHENSIVE REPORT. Michigan Child Guidance Institute, November 1, 1937, to December 1, 1940. Michigan Child Guidance Institute, Ann Arbor, Mich. 95 pp.

Data are presented showing that 5,000 children in Michigan reach the juvenile courts as delinquents each year. To meet this situation, recognized as constituting a real problem in home defense, the Michigan Child Guidance Institute set up a unified program for attacking every phase of the problem through research into causes, through improvements in methods of treatment, and through the coordination of the work of various agencies. In 33 months this unified program provided clinical service for 995 children from more than 35 counties.

THE RELATION OF THE MUSEUM TO TACTUAL EDUCATION, by Nelson Coon. *Teachers Forum* for Instructors of Blind Children, Vol. 14, No. 2 (November 1941), pp. 33-34, 39.

The use of museum exhibits, covering a wide variety of objects, for tactual education of blind children at Perkins Institution is described, and suggestions are given for the use of such exhibits. For example, the number of objects in an exhibit should be limited to 10 or 12; they should be every-day objects, three-dimensional, and free from imperfections.

INTO HIGH GEAR. Canadian Welfare Council, Council House, Ottawa, 1941. 22 pp. Mimeographed. An appraisal of welfare and community problems in Canada in the light of the war effort.

DEXTER, by Stanley H. Silverman. Simon & Schuster, New York, 1941. 63 pp. \$1.50.

Dexter is a dragon—a baby dragon. As a dragon he belongs to a group with whom the rest of the animals will have nothing to do. Dexter is unhappy in the land of the dragons and starts out on an adventure to find a way to play with the "children" of the other animals. His adventures are exciting on the childish level. There is a subtle depth to the story, which shows how the intolerance of the animals is broken down by the appealing and friendly baby dragon. The pictures and the format of the book add to the attractiveness of the story.

case workers in the public-welfare offices more and more see need for psychological help with young adults needing vocational training.

The growth and expansion of this program may be interpreted as indicating that in States where psychological services are not available in the school systems it is perfectly feasible to introduce such services through the child-welfare program.

CONFERENCE CALENDAR

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| <p>Mar. 25-26 Conference of State and Territorial Health Officers with the United States Public Health Service, Washington, D. C.</p> <p>Mar. 27 Conference of State and Territorial Health Officers with the Children's Bureau, Washington, D. C.</p> <p>Apr. 1-3 American Academy of Pediatrics, Region I, Philadelphia. Publicity Committee: Mary K. Bazemore, M. D., The Embassy, 2100 Walnut St., Philadelphia.</p> <p>Apr. 6-10 Second American Congress on Obstetrics and Gynecology, St. Louis, Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago.</p> <p>Apr. 6-10 Association for Childhood Education. Golden jubilee, Buffalo, N. Y. Information from Association for Childhood Education, 1201 Sixteenth St., NW., Washington, D. C.</p> <p>Apr. 7-9 Eighth annual conference on the Conservation of Marriage and Family Life, at the University of North Carolina and Duke University. Information: Professor Ernest R. Groves, University of North Carolina, Chapel Hill, N. C.</p> <p>Apr. 10-11 American Academy of Political and Social Science. Philadelphia.</p> <p>Apr. 14 Pan American Day. For publications and information write to the Pan American Union, Washington, D. C.</p> <p>Apr. 21-23 New England Public Health Institute. Providence, R. I.</p> <p>Apr. 27-May 1 National League of Women Voters. Biennial conference, Chicago.</p> | <p>Apr. 30-May 2 American Pediatric Society, Skytop, Pa.</p> <p>May 2-9 Eighth Pan American Child Congress, Washington, D. C.</p> <p>May 4-9 National Congress of Parents and Teachers. San Antonio.</p> <p>May 5-8 International Association of Public Employment Services. Louisville.</p> <p>May 6-7 Association of Juvenile Court Judges of America. Annual Conference, New Orleans.</p> <p>May 6-8 National Council of State and Local Welfare Administrators. New Orleans.</p> <p>May 6-9 National Tuberculosis Association. Thirty-eighth annual meeting, Philadelphia.</p> <p>May 7-9 National Probation Association. New Orleans.</p> <p>May 10-16 National Conference of Social Work. Sixty-ninth annual conference, New Orleans.</p> <p>May 18-23 Biennial Conference of Nursing Organizations, Chicago. (National Organization for Public Health Nursing, American Nurses' Association, and League for Nursing Education.)</p> <p>June 21-25 American Home Economics Association. Thirty-fifth annual meeting, Boston.</p> <p>June 22-27 American Library Association. Sixty-fourth annual conference, Milwaukee.</p> <p>June 28-July 2 National Education Association. Eightieth annual convention, Denver.</p> |
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UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

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The

CHILD

*** Monthly Bulletin ***



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CHILDREN'S BUREAU

APRIL 1942



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

Report Adopted March 18, 1942, by the Children's Bureau Commission on Children in Wartime

A Children's Charter in Wartime

WE ARE in total war against the aggressor nations. We are fighting again for human freedom and especially for the future of our children in a free world.

CHILDREN must be safeguarded—and they can be safeguarded—in the midst of this total war so that they can live and share in that future. They must be nourished, sheltered, and protected even in the stress of war production so that they will be strong to carry forward a just and lasting peace.

OUR AMERICAN Republics sprang from a sturdy yearning for tolerance, independence, and self-government. The American home has emerged from the search for freedom. Within it the child lives and learns through his own efforts the meaning and responsibilities of freedom.

WE HAVE FAITH in the children of the New World—faith that if our generation does its part now, they will renew the living principles in our common life, and make the most of them.

BOTH as a wartime responsibility and as stepping-stones to our future—and to theirs—we call upon citizens, young and old, to join together to—

- I. Guard children from injury in danger zones.
- II. Protect children from neglect, exploitation, and undue strain in defense areas.
- III. Strengthen the home life of children whose parents are mobilized for war or war production.
- IV. Conserve, equip, and free children of every race and creed to take their part in democracy.



Photo by Strichen

The Charter in Terms of the Children of the United States

I. DANGER ZONES

"Guard children from injury in danger zones"

These danger zones line our coasts along the Atlantic, the Pacific, and the Gulf—especially where there are military targets, industrial plants, business centers, oil tanks or the like; also, closely built home areas which might be bombed in an effort to break the morale of defense production workers.

These zones are a first charge on our Civilian Defense program but there is no certainty that inland districts and communities will not be subject to air raids or other forms of attack.

Children first in all plans for protection. The first step is their registration and identification.

Evacuation of children from such zones, if needed, as a sound precaution; advance plans for adequate reception and care in their places of refuge. Mothers to go with their children whenever possible.

"War vacations" for city children.—By the expansion of summer vacation camps conducted under proper supervision, staffed in part by volunteers, and utilizing surplus commodities, and other aids, great numbers of children can be removed from exposed districts at relatively little expense. These camp demonstrations would be an admirable test of evacuation methods and an investment for health.

Appropriate immunization of all children against communicable disease.

Helping children to meet the anticipations and realities of wartime.—Childhood anxiety can be as devastating as disease. Not only parents, but doctors, nurses, teachers, recreation leaders, settlement workers, child-welfare and child-guidance workers can help to preserve the child's sense of security, which is his greatest need.

II. DEFENSE AREAS

"Protect children from neglect and undue strain in defense areas"

Vital to the cause of the United Nations is an ever-increasing stream of guns, tanks, and

planes and other war equipment and materials from the United States. A thousand communities are involved in their production. Broken working time due to sickness of the worker, or his wife or child, or to disturbed family life, handicaps production at countless points.

Therefore, the following are essential:

Adequate health, education, and welfare services must be maintained for children and their parents in each of the thousand communities where war production or military camps are established. To accomplish this will require proper staffing with doctors, health officers, nurses, social workers, teachers, recreation leaders and librarians. It will call for adequate hospitals, clinics, schools, playgrounds, recreational facilities, and day-care centers. Each of these communities will need to mobilize all of its resources within a coordinated plan. Many will need assistance to supplement existing staff and equipment.

The assignment of obstetricians and pediatricians to defense areas should be given special consideration.

Child-guidance clinics should be provided wherever possible to help parents and children overcome insecurity associated with dislocations in family life. Such dislocations exaggerate the normal anxieties of children and create situations that require special service.

School opportunities must be expanded to meet the new demands of expanding populations. This should include nursery schools for young children.

Recreation leaders, group workers, and child-welfare workers are urgently needed in defense communities, where crowded conditions mean overtaxing of facilities for play of little children and of recreation centers for older boys and girls; increase in harmful employment of children; and mounting juvenile delinquency.

III. HOMES IN WARTIME

"Strengthen the home life of children whose parents are mobilized for war or war production"

To children in wartime the home is vital as a center of security and hope and love. To our fighting men the safety and protection of their families is the center of what they fight for. To men on the production front the welfare of their families and homes is basic to morale.

Migration to new and crowded communities, the absence of the father in military service, priorities unemployment on the one hand, and the employment of mothers on the other, are creating problems in homes that affect every member of the family.

Children of our fighting men. Full provision must be made for the economic needs of children whose fathers are in the service and for medical and hospital care for wives and children.

A Government insurance program for civilians injured or killed as a result of war activities should supplement our social-security program.

Adequate housing is essential to the protection of home life. In housing projects facilities should be provided for health services and group activities for children.

Employment of mothers and day care of children.—As plans develop for the participation of women in war industry, it must be recognized that the care of young children is the first responsibility of mothers. For children whose mothers are employed or planning to enter employment, it is the responsibility of the community, through adequate planning and support, to see that parents have assistance in planning for their needs and that the children have the best possible care—not forgetting health supervision, opportunity for nursery education and play for the youngest, recreation outside of school hours for those who attend school.

Day care for children in crowded areas where home facilities are limited.—Such children should have opportunities similar to those provided for children of working mothers.

Economic security.—To all parents economically unable to maintain a home for their children, Government help should be extended through such measures as aid to dependent children, general assistance, and benefits for temporary and permanent disability.

IV. CHILDREN THE COUNTRY OVER

"Conserve, equip, and free children of every race and creed to take their part in democracy"

The Children's Charter drawn up at the White House Conference in 1930 and the recommendations of the 1940 Conference are still a challenge to the people. Here it is only in point to single out certain factors that take on new significance in the present war crisis.

Health and children.—Good health in childhood lays the foundation for good health in later life. Children should have health supervision from the prenatal period through adolescence. Special planning is needed to overcome present and future shortages of doctors and nurses. As soon as possible every county in the United States should have public-health-nursing service, prenatal clinics, delivery care, child-health conferences, and clinic and hospital service for sick children.

Food for children.—The needs of children must be considered first in the event of national or local short-

ages of foods, especially of milk and the other protective foods. If our country is to be strong, all children must have the food they need for buoyant health and normal growth, and information must be available to parents concerning the family food requirements. Family incomes should be sufficient to assure to each member of the family the right amounts and the right kinds of food. School meals are an effective means of supplementing home nutrition and educating children and their families in good food habits. The extension of penny milk to all children is an important aid in assuring to them their full share of this essential food.

Social services for children.—Communities should be equipped to supplement the care and training given by home and school when the welfare of the child demands it. Child-welfare and child-guidance resources of the State, county, and city governments should be expanded to provide appropriate service and care for all children with special needs.

The right to play.—More than ever in wartime recreation must be assured for children and youth through the full use and expansion as needed of all public and private leisure-time activities.

School and work.—It is essential that children and youth be sound and well prepared in body and mind for the tasks of today and tomorrow. Their right to schooling should not be scrapped for the duration. Demands for the employment of children as a necessary war measure should be analyzed to determine whether full use has been made of available adult manpower and to distinguish between actual labor shortage and the desire to obtain cheap labor. The education and wholesome development of boys and girls should be the first consideration in making decisions with regard to their employment or other contribution to our war effort. This means that no boy or girl shall be employed at wages that undermine the wages for adult labor; none under 14 years of age shall be part of the labor force; none under 16 shall be employed in manufacturing and mining occupations; none under 18 in hazardous occupations.

Health and education.—A measure urgently needed at this time is complete medical examinations of all boys and girls of high-school age at regular intervals, with provision for correction of remediable defects. Provision should be made for a Nation-wide extension of health services for school children including medical care as needed and health instruction, developed through the cooperation of health and education authorities. The need for health supervision and medical

care for youth has been demonstrated until there is no longer any possibility of disregarding it. Education should be given to the needs of all young

Young children.—In the war period special considerations for security in the home and for opportunity to grow through association with other children in play and through the reassurance given by adults who have learned to understand their needs. Opportunity for nursery education should be made increasingly available to help meet situations created by the war.

Children in rural areas.—More than half of the children of the Nation live in country districts. Far more than city children they are likely to be handicapped by early and harmful employment, inadequate schools, and lack of other community facilities. The war effort must not increase these handicaps.

Participation in civilian-mobilization programs.—Boys and girls should participate in home and community efforts for the war through activities appropriate to their age and ability.

Every city, county, and State should review the needs of its children and youth in the light of these principles through a children's wartime commission or council or an existing organization designated to serve in this capacity, and should devise means to meet evident needs through the cooperative action of Federal, State, and local Governments and private agencies.

Every effort should be made to keep the public informed of activities and needs in all phases of service for children and to provide for participation of professional associations, organized labor, farm groups, and other organizations of citizens concerned with children, in the planning and development of these programs.

Provision should be made as rapidly as possible for training the professional workers needed to provide for extension of community programs to increasing numbers of children.

There should be no State lines nor barriers of race or creed impeding what we do for children in our war effort. They may not live in danger zones or defense areas; they will still be subject to the strains of these times. They should not be forgotten Americans. Their future is our future.

The Children's Bureau in Peace and in War

A Review on the Occasion of the Bureau's Thirtieth Anniversary

By MIRIAM KEELER, *Editor of The Child*

Foreword

By KATHARINE F. LENROOT, *Chief of the Children's Bureau*

In a recent article, Child Welfare in the United States,¹ the director of a school of social work in a sister Republic to the south, made this keen and thoughtful observation:

In summary: I do not believe that dollars alone are the key to the notable advance in social welfare in the United States. At least there is another great force: collaboration. * * * the why of that coordination * * * is a simple educational process. It is called "teamwork."

Whatever the Children's Bureau has been able to accomplish in the last 30 years has been due to the spirit of "teamwork," both within the staff of the Bureau and in its relationships with other agencies and with the great organizations through which citizens express their concern for

community welfare. It is fitting, therefore, that this review of the aims of the Children's Bureau and what it has stood for during a period of nearly a third of a century, should be the work of an editor, whose daily task is to bring together for publication in *The Child* the fruit of all the interest and experience which comes within the Bureau's fields of research and of action.

It is significant, also, that this anniversary number should go to press during the week of the first session of the newly established Commission on Children in Wartime. There could be no better symbol of the Bureau's thirtieth anniversary than the Charter for Children in Wartime adopted by the Commission. It is for all who care about children to see that the goals set forth in that charter are pursued in all the stress of wartime, in every home and every community throughout the land.

¹ Translation of an article by Marta Ezcurra, a recent visitor to the United States, in *Anales de La Sociedad de Puericultura* (Buenos Aires), vol. 7, No. 3 (July-September 1941).

Services essential for health and welfare must be maintained and bulwarked under any sound national program in war as in peace. Especially is this true of services for children, on whose well-being depend the vigor and competence of the men and women they will become. In this category of activities falls the work of the Children's Bureau, established by an Act of Congress approved on April 9, 1912.

"What we would do for children this year," Grace Abbott used to say, "cannot be postponed

until next year, for children do not wait upon convenience."

During recent months the country has had to eat the pudding that proves the truth of Miss Abbott's words and is finding it bitter pudding indeed. Of the young men given physical examinations under the Selective Training and Service Act of 1940, 40 percent failed to measure up as physically fit for general military service. The men examined ranged in age from 21 to 35 years. As interpreted in Public Health

Reports,² "the effect of deferments for reasons other than physical status tends to concentrate the group examined in the ages 21 to 25, the period when physical health should be at its best." Many deferments were for remediable physical defects.

These young men are the babies born during the first World War, when the Children's Bureau was beginning its work. The youngest were born during the winter of 1918-19, when the influenza epidemic sapped the strength of mothers and shot the maternal mortality rate up from 66 per 10,000 live births to 92, an increase of nearly 40 percent. These young men were schoolboys and adolescents in the early 1930's when unemployment and low wages depressed living standards to the danger point.

In Washington County, Md., it was possible to match the selective service records of 411 men against records of physical examinations given to them as school children during school surveys made by the Public Health Service in the 1920's.³ Of this group 55 percent were rejected for general military service because of physical or mental conditions. Defects of the same nature as those which caused the rejection of the men in 1940 had been observed in a very high proportion of the same individuals some 15 years earlier when they were in elementary school. For example, almost all (96 percent) of the children who later were to be rejected already had one or more decayed, missing, or filled permanent teeth; but in less than three-fourths (73 percent) of the children later to be accepted was such a condition found.

The Sheppard-Towner Maternity and Infancy Act, in operation from 1922 to 1929, came too late to benefit their generation at birth. Their preschool years and for the most part their school years were over before the Social Security Act was enacted in 1935.

Among these men are the youngsters who were caught in the wave of sweatshop industry of the early depression years, before a 16-year

age minimum for employment was adopted under the industrial codes of the National Recovery Administration in operation from 1933 to 1935, or the Fair Labor Standards Act was passed in 1938. Among them are the youth who idled and despaired during the depression years when jobs were few and wages low.

"Too little and too late" should never be true of services to children. For the infants born this year and their mothers, the preschool children and the children in school, the children who are crippled or maladjusted socially, the children in need of special services, the older boys and girls leaving school for work—much can now be done, much is being done that was known only in the dreams of farseeing men and women such as those who were responsible for the creation of the Children's Bureau, 30 years ago.

What has been accomplished by the Children's Bureau in these 30 years has been done in co-operation with other Federal agencies, with State and local agencies, with private organizations both national and local, and with interested individuals. Especially valuable has been the stimulus provided by the White House Conferences held at intervals of approximately a decade.

The White House Conferences.

The White House Conference on Care of Dependent Children, held in 1909, preceded the establishment of the Children's Bureau, and served to crystallize the movement for a Government bureau devoted to the interests of children. The White House Conference on Child Welfare, in 1919, came at the end of the first World War and served to focus on the needs of children the renewed interest in constructive programs of health and social welfare.

The White House Conference on Child Health and Protection, held in 1930, brought together in a comprehensive set of reports the results of medical, social, and industrial research in the children's field and adopted the Children's Charter, which has served ever since as a touchstone for measuring standards of child health, child welfare, and child labor in times of peace.

The White House Conference on Children in a Democracy, meeting in 1939 and 1940, devel-

² Britten, H. R., and G. St. J. Ferrott: Causes of Physical Disqualification Under the Selective Service Law—Early Indications. *Public Health Reports*, vol. 56, No. 19 (May 9, 1941), pp. 1017-1021.

³ Ciocco, A., H. Klein, and C. E. Palmer: Child Health and the Selective Service Physical Standards. *Public Health Reports*, vol. 56, No. 50 (December 1941), pp. 2365-2375.

oped long-range objectives in all phases of work with children with the definite aim of preserving democratic standards and ideals under the renewed threat of war.

Saving Infant Lives.

When the Children's Bureau began its work, no one knew just how large a proportion of the babies born alive in the United States died in their first year of life. It was impossible to get statistics on this because there was no Nation-wide system of birth registration in the United States 30 years ago. In the first annual report of the Chief of the Children's Bureau, Miss Lathrop quoted an estimate of the Bureau of the Census that 300,000 babies had died in the preceding year and that "at least half would now be living had we, as individuals and communities, applied those measures of hygiene and sanitation which are known and available."

One of the earliest objectives of the Bureau was the establishment of birth registration as the initial step in measuring infant mortality and thus in beginning to control it. The birth-registration area was set up in 1915 by the United States Bureau of the Census with 10 States and the District of Columbia included, and gradually was extended to include more States as they were able to meet the requirements. Since 1933 the birth-registration area has included the whole of continental United States, and the Virgin Islands and Hawaii.⁴ The infant mortality rate in the expanding birth-registration area has been reduced from 100 per 1,000 live births in 1915 to 47 in continental United States in 1940, the latest year for which figures are available from the Bureau of the Census. The number of infants who died in 1940 was 110,984. Thus, both in actual numbers and in proportion to the number of live births, the death rate for infants in this country has been more than cut in half since the Bureau was established.

Saving Mothers' Lives.

The large numbers of deaths of women from causes associated with pregnancy and childbirth have been of grave concern to the Bureau

from the beginning. But for many years the maternal mortality rate remained obstinately in the vicinity of 60 per 10,000 live births (61 in 1915 in the newly established birth-registration area and 62 in 1933 in continental United States as a whole). Since 1935, however, when the Social Security Act was passed, carrying provisions for Federal aid to States for maternal and child-health services, the drop in maternal deaths has been spectacular.

The Chief of the Children's Bureau predicted 5 years ago that the maternal mortality rate, which was 58 per 10,000 live births in 1935, could be pulled down to 38 within 10 years. In this respect progress has come more quickly than was anticipated. The 1940 rate was 37.6 per 10,000 live births—a drop of 20 points in 5 years instead of a decade.

The Social-Security Program.

Health services for mothers and children through aid to the States, carried on from 1922 to 1929 under the Sheppard-Towner Maternity and Infancy Act, have been reestablished and extended and services for crippled children and child-welfare services have been set up under the Social Security Act passed in 1935. All the States, the District of Columbia, Alaska, Hawaii, and Puerto Rico now operate these three programs under plans approved by the Chief of the Children's Bureau with the aid of Federal, State, and local funds.

The amount of the Federal appropriations authorized for maternal and child-health services and services for crippled children was substantially increased by amendments to the Social Security Act enacted in 1939. However, these increases were based on normal and comparatively stable conditions. The mushroom growth of defense industries in rural areas and small communities and the accompanying shifts in population have created needs that these funds could not be stretched to meet, although the States have done the best they could to meet emergency conditions without depriving children in areas with established programs of needed services.

But if the fundamental health and welfare of the children of today—the men and women of tomorrow—are to be safeguarded in what-

⁴ Birth, Stillbirth, and Infant Mortality Statistics: 1933. P. 3. United States Bureau of the Census, Washington, 1936.

ever emergency may arise as a result of the war situation, additional funds will be needed for allocation on short notice as the need occurs.

This spring, as a special feature of the May Day—Child Health Day observance, the President of the United States has stressed the importance of immunizing all children over 9 months of age against smallpox and diphtheria. This is a precautionary measure against the dangers of contagion arising from large-scale migration, possible evacuation of children from coastal areas, crowded housing, and sketchy sanitation in new defense areas. A May Day drive for immunization is being carried on by the health department in each State.

Child Labor.

The 30 years since 1912 have seen the invaluable addition of a year or more to the childhood of our boys and girls and to their schooling. Many of the children who now continue in school until they finish the eighth, ninth, or tenth grade at the age of 16, have fathers and mothers who went to work at 14 or younger and never reached the seventh grade in school. Moreover, the conditions of work for today's 16-year-olds are better than those for the 14-year-olds of a generation ago: Work permits are required in most States at least for minors under 16; the working day is 8 hours or less instead of 10 hours or more; there are more restrictions on night work and work in hazardous occupations. There are some States in which a 14-year-old child may still leave school and go to work—although not in any establishment covered by the Fair Labor Standards Act of 1938—but in general these are the States that permitted 12-year-old children to work a generation ago.

These results have been accomplished partly through State legislation and partly through Federal legislation—and wholly through an awakening social consciousness of our responsibility toward youth, which gave rise to the legislation and to better employment policies. On the Federal level there have been four well-defined mile posts: The first Federal Child-Labor Law, in effect in 1917 and 1918; the second Federal Child-Labor Law, in effect in

1919–22; the industrial codes adopted under the National Recovery Administration in 1933–35; and the Fair Labor Standards Act of 1938.

Fair Labor Standards Act.

Under the Fair Labor Standards Act of 1938, the child-labor provisions of which are administered by the Children's Bureau, a 16-year minimum age for employment has been established for concerns producing goods shipped in interstate commerce. A system of issuing age certificates for minors entering employment has been set up in cooperation with State authorities. Inspections have been carried on to determine compliance of employers with the provisions of the act.

Studies of a number of industries have been made to determine occupations especially hazardous for minors, and 5 hazardous-occupations orders have been issued establishing an 18-year minimum age for employment in the occupations covered. A hearing has been held on a sixth order, which is expected to become effective in May (see p. 275). Further studies of hazardous occupations are being directed toward war industries in order that young workers of 16 and 17 may enter the safer jobs and minimize, at the time when their youth and inexperience make them particularly vulnerable, risks of disabling injuries and loss of their productive powers.

The number of minors employed, which was at a minimum during the years of depression, has been skyrocketing in recent months. It is essential that safeguards be kept on the conditions under which minors of legal working age are employed, especially in regard to hours and occupational hazards; and that precautions be taken against the exploitation of young children that are hired for farm labor at the expense of their health or education.

Social Services for Children.

In the early days of the Children's Bureau social services for children were restricted for the most part to cities and were directed only toward children who were orphaned, neglected, abused, or for some other reason were in need of special care. Gradually a broader concept of child welfare has been accepted, looking

toward the provision of environmental conditions, including material resources, favorable to the social, mental, and physical development of children in general as well as toward enabling individual children to realize the satisfactions of security, self-expression, and personal achievement.

Services to children in rural areas have been extended and strengthened since 1935 through State-wide plans for child-welfare services carried out by the State and local welfare departments with the cooperation of the Children's Bureau and with the aid of Federal funds under the Social Security Act. Some 50,000 children were given service last year by child-welfare workers paid in whole or in part by Federal funds. The program for aid to dependent children carried on by the States in cooperation with the Social Security Board has also been developed under the Social Security Act.

Increasing emphasis has been laid on the prevention of juvenile delinquency through community organization and on the treatment of behavior problems in their early stages through child guidance, group work, and child-welfare services.

The practical result of this emphasis should be to reduce the number of boys and girls in training schools for delinquent children. And that is exactly what has happened. Tentative results from a questionnaire sent to State training schools indicate that the population in training schools for boys had decreased 16 percent, and in those for girls, 13 percent in January 1942 compared with January 1938. Although many factors doubtless contributed to this decrease, the one mentioned most often in the comments of the training-school authorities was the improvement in local services for children.

The need for all these services is in no way reduced or postponed by the war situation. On the contrary, it is intensified. It is admitted in England that the failure to give sufficient consideration during the early months of the war to the problems created by the disruption of home life due to military service, work in war industries, and evacuation of children from

danger zones was responsible for a marked increase in juvenile delinquency.

Already sporadic reports are coming in indicative of a rise in juvenile delinquency in some sections of this country. In one area a 500-percent increase occurred in the number of cases of juvenile delinquency reported. If this country is not to duplicate the unfortunate experience of England, increased attention must be given to supervised recreation, group-work activities, child-guidance, and child-welfare services, and to the integration of these facilities into a broad community program.

Areas in which defense industries are located present especially acute problems of child welfare. Of nearly 500 counties listed recently as having defense activities, 209 have child-welfare workers for whose employment the social-security program was to some degree responsible. In 17 areas a child-welfare program has been set up within the year to meet defense needs.

Certain special needs of children have come to the fore as a result of the defense effort. Day care for children of employed mothers is one of those on which the Bureau has been concentrating attention. Another is the perfecting of plans under which children can be evacuated if necessary from areas of potential danger.

Commission on Children in Wartime.

So pressing and so varied have become the problems facing the Bureau in attempting to meet the wartime needs of children and youth that a Children's Bureau Commission on Children in Wartime has been set up. As there is no phase of child life that is unaffected by the war situation, the chairmen of all the advisory committees of the Bureau have been asked to serve on the commission, which also includes representatives of State and National organizations serving children. At the first meeting of this commission, March 16 to 18, 1942, plans were made for developing its work in an orderly and comprehensive fashion and a Charter for Children in Wartime was adopted.

The Children's Bureau in World Affairs.

International cooperation for the promotion of child welfare has long been an important

feature of the Children's Bureau work. This has been carried on in the past largely through the Advisory Committee on Social Questions of the League of Nations and through the International Labor Organization. In spite of the war situation, which has disrupted social services in most European countries, some research and information work is being continued by these organizations from their temporary headquarters in the United States and Canada, and a continuing thread of international understanding is being maintained as a basis for post-war reconstruction.

Cooperation with the other American Republics has taken on added importance as the world outlook has darkened. The Chief of the Children's Bureau represents the United States as a member of the American International Institute for the Protection of Childhood, with headquarters at Montevideo, Uruguay. At the present time a social worker from the Children's Bureau is working in Montevideo with the Institute and another is in Asuncion, Paraguay, helping the Ministry of Public Health to develop

plans for a children's bureau in Paraguay. Last year through a special arrangement a pediatrician and a social worker from the Bureau spent some months in Brazil, assisting the National Children's Bureau of Brazil, at its request, in surveying the possibilities of developing social services for children in that country.

The Pan American Child Congresses have been another avenue of inter-American cooperation ever since 1916 when the First Congress was held in Buenos Aires. The Seventh Congress took place in Mexico City in 1935. The Eighth, originally planned to be held in Costa Rica in October 1939 and postponed because of the outbreak of war in Europe, is to be held in Washington in May 1942. The Organizing Committee for the Congress, with the Chief of the Children's Bureau as chairman, has planned the program and agenda to be of the utmost practical importance in providing, on a basis of international collaboration, for the protection of children in this hemisphere during the war and post-war periods.

Recent Children's Bureau Publications

MATERNAL AND CHILD-HEALTH SERVICES UNDER THE SOCIAL SECURITY ACT; development of program, 1936-39. Bureau Publication No. 250. Washington, 1941. 109 pp. Covers the first 4 years of Federal and State cooperation under title V, part 1, of the Social Security Act.

THE CHILDREN'S BUREAU TODAY. Washington, February 1942. 20 pp. Multilithed. Describes the functions of the Children's Bureau and includes an organization chart showing the set-up of Bureau activities.

CHILD LABOR AND INADEQUATE FAMILY INCOME. Washington, 1942. 18 pp. Mimeographed. A preliminary report on a study carried on by the Children's Bureau of the work and welfare of children of agricultural laborers in Hidalgo County, Tex.

TRAINING PROGRAMS FOR CHILD-CARE VOLUNTEERS. Washington, 1941. 15 pp. Mimeographed. Information regarding the organization of training courses

for volunteers in child care, including a list of selected publications issued by Federal Agencies which are available for use in volunteer courses.

OUTLINE FOR LECTURES ON CHILD CARE. Washington, March 1942. 25pp. Mimeographed. Suggested materials for use with course for child-care volunteers, included in the manual, *Volunteers in Child Care*, prepared by the Children's Bureau for the Office of Civilian Defense.

MANUAL FOR TEACHING MIDWIVES, by Anita M. Jones. R.N. Children's Bureau Publication No. 260. Washington, 1941. 139 pp. The nurse-midwife who prepared this manual is assistant director of the Maternity Center Association, New York. The manual is intended for the use of nurse-midwives in teaching untrained midwives to use aseptic techniques, never to interfere with the delivery, and to call the doctor at the first sign of danger. It is written in simple language and illustrated with diagrams.

The Eighth Pan American Child Congress

Washington, May 2-9, 1942

AGENDA

As revised in the light of the entry of the United States and certain of the other American Republics into the war, the agenda for the Eighth Pan American Child Congress give special emphasis to measures for maintaining and strengthening essential services to meet war-time needs and to laying the foundations for closer inter-American collaboration for the protection of childhood in the war and post-war periods. In determining the basis upon which the meeting is to be held, the Organizing Committee consulted Government agencies, organizations, and individuals in the other American Republics as well as in the United States and came to the conclusion that under war conditions it is even more important than in peace times to proceed with plans for the promotion of inter-American cooperation in the protection and welfare of children.

The major work of the Congress will be carried on by the delegates meeting in general session. The papers submitted will be reviewed in section meetings as follows:

- I. Health protection and medical care.
- II. Education and recreation.
- III. Economic and social services for families and children.

Four special committees will be established to study the needs of children in wartime and in the post-war world:

1. Committee on Essential Services for Mothers and Children in Wartime.
2. Committee on Protection of Mothers and Children in Danger Zones.
3. Committee on Plans for Children in the Post-War World.
4. Committee on Inter-American Cooperation.

The official languages of the Congress will be Spanish, Portuguese, French, and English.

A Resolutions Committee composed of seven official delegates to the Congress will present resolutions and recommendations at the final session of government delegates. Action will be by majority vote, each country having one vote.

PROGRAM

In addition to business and social sessions, section meetings, and committee meetings, the tentative program includes the following sessions:

Saturday, May 2

- 3:00 p. m. Preliminary session of official delegates.
9:00 p. m. Inaugural session.

Monday, May 4

- 10:30 a. m. Inter-American cooperation for the protection of children in peace and war.
Essential needs of children and effect of war conditions.
2:30 p. m. Progress since the last Congress in the development of services for—
Health protection and medical care.
Education and recreation.
Economic and social services for families and children.
Effect of wartime conditions on these services.

Tuesday, May 5

- 10:00 a. m. Discussion of measures for maintaining and strengthening necessary services for children to meet wartime needs—
Protection of maternal and child health.
Education, recreation, and conditions of employment of young persons.
Family security and social services for children.
2:30 p. m. Facing the problem of nutrition in the Americas—
Essentials of good nutrition for children.
Measures to encourage an adequate food supply.

How health, education, and social-welfare agencies can help parents and children to follow good nutrition standards.

Wednesday, May 6

10:00 a. m. Special measures for the protection of children in wartime—

The protection of children in danger zones.

Planning for care of children after evacuation arising from military necessity.

9:00 p. m. Planning for children in the post-war world.

Inter-American cooperation for child welfare.

Friday, May 8

10:00 a. m. Committee reports and discussion—

Essential services for mothers and children in wartime.

Protection of mothers and children in danger zones.

2:30 p. m. Committee reports and discussion—

Plans for children in the post-war world.

Inter-American cooperation.

Saturday, May 9

10:00 a. m. Session of official delegates.

3:00 p. m. Formal closing session.

Progress in Child Welfare in the American Republics

By ANNA KALET SMITH

Office of the Chief, Children's Bureau

A review of developments since 1935 in the field of child welfare in the several American countries, to be made before the Eighth Pan American Child Congress, was called for by a resolution of the Seventh Congress. It is especially appropriate, therefore, that such a review be published on the eve of the Eighth Pan American Child Congress.¹

Each of these international gatherings from their small beginning in 1916 has been followed by some concrete evidence of results in the form of child-welfare improvements in one country or another. The 6 years since the last Congress have been particularly significant in this respect, a fact which may be attributed to the results of the preceding Congresses and to the increasing recognition of the social value of the child, itself both a cause and an effect of these Congresses.

Progress has been most evident in three fields: coordination of child-welfare work, nutrition, and social insurance.

COORDINATION OF CHILD-WELFARE WORK

The need for coordination of all child-welfare services for the purpose of greater effectiveness was the predominant note that kept recurring

throughout these Congresses. Action to bring about such coordination, preferably under a single national agency and with particular regard to the needs of rural localities, has been taken in several countries in the last 6 years.

Argentina.

The Bureau of Maternal and Child Welfare (*Dirección de Maternidad e Infancia*) was established in the National Department of Health in Argentina by a law of 1936 for the purpose of protecting the health of mothers and of children under 6 years of age in the entire country. This Bureau, replacing the Division of Child Welfare, has much broader powers and a greater field of action than its predecessor. It consists of several divisions, each in charge of some phase of maternal and child health and welfare, such as supervision of public and private agencies and coordination of their work; determination of standards for medical and social services; organization of maternal and child-health agencies; study of problems pertaining to children throughout the country; and education of the public in personal and general hygiene and in nutrition.

In 1940 the Bureau maintained and supervised many maternal and child-health centers and opened a number of new ones. Like other countries, notably Mexico and Brazil, Argentina has been extending its health facilities to remote sparsely populated localities, and in

¹ The Pan American Child Congresses were held as follows: Buenos Aires, Argentina, 1916; Montevideo, Uruguay, 1919; Rio de Janeiro, Brazil, 1922; Santiago, Chile, 1924; Havana, Cuba, 1927; Lima, Peru, 1930; and Mexico City, 1935.

1940 a maternal and child-health center was established for the first time in Tierra del Fuego, the southernmost tip of the hemisphere. In the same year studies were made in several parts of the country of the living conditions of preschool children and medical-social services for them; several new dental clinics for mothers and children were equipped and made ready for opening in 1941; the teeth of kindergarten children were examined; health education was conducted over the radio and with specially prepared motion pictures, posters, and leaflets; a study was made of the birth rate, of infant mortality and general mortality, from several causes, in Buenos Aires and other parts of the country. Social workers are employed by the health centers for visiting the homes and for other purposes. In 1941 a traveling medical-dental clinic began to operate in Buenos Aires, which has 140,000 children of preschool age.²

Bolivia.

The Bureau of Maternal and Child Welfare (Patronato Nacional de Menores) was created by decree of 1937. Among the Bureau's functions are supervision of public and private child-welfare institutions and welfare work for destitute children. Committees were established in the Provinces to help in the Bureau's work.

Brazil.

The demands for a better organization of child-welfare work in Brazil to meet new conditions resulted in the creation of the National Children's Bureau (Departamento Nacional da Criança) in 1940. For the first time in that country was a single government agency assigned the task of coordinating all maternal and child-welfare activities. The Bureau is also directed by law to stimulate the organization of health and welfare work for mothers and for children from birth to adolescence and to supervise this work. Faced by this vast assignment, further complicated by the great diversity of local conditions in an enormous country, the Bureau began with the most urgent

problem, that of reduction of maternal and infant mortality. To this end it has been helping to establish small maternity homes and health centers for expectant mothers and young children, with trained staffs and with facilities for regular medical examinations, for the instruction of mothers in the care of their children and themselves, and for the distribution of milk for babies. Grants for these purposes were distributed by the Bureau to municipalities in 1940 and 1941, and an appropriation is available for 1942.³

Chile.

The Bureau of Maternal and Child Welfare (Departamento Central de Madre y Niño) of the Ministry of Health was established in Chile in 1940 to coordinate the work of the public and private agencies devoted to maternal and child welfare and to prepare a program for child-welfare work by the State. According to the Message to Congress of the President of the Republic of Chile dated May 21, 1941, such a program was prepared in the first year of the Bureau's existence. Regulations governing the Bureau's work were issued; and an inquiry was made as to the organization and aims of all public and private agencies engaged in maternal and child-welfare work throughout the country. Branches of the Bureau were set up in several Provinces. In Santiago 12 persons were appointed, without remuneration, to make a census of the welfare agencies and to study the best way of coordinating their work.

The Bureau has begun a follow-up study of newborn infants. The offices of vital statistics send daily lists of births registered with them, and the maternity homes also report births. Social workers visit the homes of these children in order to ascertain the economic condition of the families and the children's state of health; when necessary the children are referred to one of the local child-welfare agencies.

A plan has been prepared for enlarging the maternal and child-welfare work in five provinces.

² Argentina, Ministerio del Interior, Departamento Nacional de Higiene, Dirección de Maternidad e Infancia, Buenos Aires, 1939; Boletín Sanitario, Buenos Aires, January-March 1941; Informaciones Argentinas, Buenos Aires, December 15, 1941.

³ Diário Oficial, Rio de Janeiro, February 23, 1940, sec. 1; Boletim Trimestral do Departamento Nacional da Criança, Rio de Janeiro, vol. 1, No. 1 (June 1940); Bra-Il-Médico, Rio de Janeiro, December 13, 1941.

Colombia.

The Bureau of Maternal and Child Welfare (Departamento de Protección Infantil y Materna) of Colombia was established by decrees of 1938 and 1939 in the Ministry of Labor, Health and Social Welfare. The Bureau consists of two divisions: (1) Eugenics, maternity, and infancy, and (2) preschool children, school children, neglected, ill, and defective children. It was assigned the direction of the medical, health, and social work of the existing agencies and of those to be established in the future, and the coordination of their work. The Bureau has been following the plan adopted in recent years in Costa Rica, Mexico, Venezuela, and other countries, of setting up health centers or health units in cities and especially in rural localities, where the need for them is greatest. The staffs of these units in Colombia are reported to consist usually of one or more physicians, several public-health inspectors, a midwife, a nurse, a social worker, and a dentist. These units provide, among other things, free treatment for syphilis and tropical and other diseases; prenatal care, childbirth attendance in the home, and preventive work and treatment for children. Child-health centers, responsible directly to the Bureau of Maternal and Child Welfare, are a part of some of these units. No information is available so far as to the number of existing units.

With this system of units the Government of Colombia has endeavored to assure uniformity of organization and of use of the money contributed by the Nation, the States, and the municipalities.⁴

Dominican Republic.

A law of November 12, 1940, provides for the creation in the Dominican Republic of a National Board of Maternal and Child Welfare (Junta Nacional de Protección a la Maternidad y la Infancia) which is to recommend the establishment of health and welfare services for mothers and children, to supervise these services,

to take measures for their improvement, and to prepare or approve the educational material to be issued by these services.

The board, consisting of four members appointed by the President of the Republic, with the Secretary of Public Health and Welfare as chairman, began to function in January 1941.⁵

Ecuador.

Under a law of 1938 a National Council on Children (Consejo Nacional de Menores) was created in Ecuador as an adjunct of the Ministry of Social Welfare and Public Assistance.

Among the Council's functions the law enumerates (1) the preparation of a plan for the gradual setting up of welfare agencies throughout the country and coordination of their work, (2) participation in all phases of child-welfare work, (3) distribution of government appropriations, and (4) enforcement of child-welfare laws. In the fiscal year 1941 the Council had answered all questions presented to it on appeal or in consultation and was ready to begin the inspection of all child-health and child-welfare agencies.⁶

Mexico.

In 1937 a law of Congress established the Bureau of Child Welfare (Departamento de Asistencia Social Infantil) and authorized it to exercise supervision over the maternal and child-welfare work by the States. With the change of the Government in Mexico in 1940 and the subsequent reorganization of the government departments, the Departamento de Asistencia Social Infantil was replaced by the present Bureau of Child Welfare (Dirección de Asistencia Infantil).

The bureau maintains in the Federal District prenatal centers, child-health centers, day nurseries, institutions for dependent children; it provides maternity care for destitute women, and has charge of the feeding of preschool and school children in the Federal District; social workers participate in the coordination of social services for mothers and children. The

⁴ Colombia, Ministerio de Trabajo, Higiene y Previsión Social, Algunas Disposiciones sobre Protección Infantil y Materna, Bogotá, 1939; Colombia, Trabajos Presentados por la Delegación de Colombia al VIII Congreso Panamericano del Niño, San José de Costa Rica, 1939.

⁵ Gaceta Oficial, Ciudad Trujillo, November 16, 1940.

⁶ Ecuador, Código de Menores, Edición Oficial, 1938; Ecuador, Informe que el Ministro de Previsión Social y Trabajo Presenta a la Nación, 1941, Quito.

Bureau also distributes among the States the Federal grants for maternal and child-welfare work, directs the establishment of various agencies, and supervises their work.

A nation-wide system of health services, including those for mothers and children, in the rural districts of Mexico was introduced in 1936 by a division (*Servicios de Higiene Rural y Medicina Social*) of the Federal Department of Health. In 1940, 121 health units or centers, each staffed with at least one physician, a nurse-midwife, and a pharmacist, were in operation. Prevention and treatment of transmissible and other diseases and improvement of sanitation have been undertaken; free medical treatment is given at the office of the unit or at home. Prenatal and obstetric services are available; educational work is done by public-health nurses; and it has been reported that increasing numbers of expectant mothers come to the units for examination. Free medical examinations are given to babies. A beginning in protecting the health of preschool and school children has been made along the following lines: immunization work, medical examinations of children and teachers, talks on personal hygiene, organization of school committees on health, and inspection of school buildings. All this work is financed in some localities by the Federal Department of Health; in others by local cooperatives.

Health education is carried on by means of lectures, brief talks, bulletins, posters, and demonstrations. In the Indian districts phonograph records in the local dialects are used.

Studies of the food habits in the various localities have been made by special employees of the Federal Department of Health; and measures have been taken in many parts of the country for the improvement of the water supply.⁷

Venezuela.

The coordination of services for children in Venezuela is being accomplished through two

agencies: the Division of Maternal and Child Health (*División Materno-Infantil*) of the Ministry of Health and Social Welfare and the Venezuelan Council of the Child (*Consejo Venezolano del Niño*). The Division of Maternal and Child Health, established soon after the organization of the Ministry of Health and Social Welfare in 1936, introduced a system of health work for mothers and children, which includes preventive examinations for well children, treatment of syphilis and other diseases, prenatal care, attendance at childbirth in maternity homes or in the patient's own home, distribution of milk for babies, and instruction of the mothers in child care. Under the division's auspices courses on child care are given for physicians, and nurses are trained in child-health work; publications on child health and diseases of children are issued.

The Venezuelan Council of the Child (*Consejo Venezolano del Niño*), in existence since 1936 but reorganized in 1939, is an official agency of an advisory and technical nature. Under the law the Council is responsible for the coordination and supervision of public and private health and welfare work for mothers and children. Other functions assigned to the Council are standardization of methods, investigation of subjects relating to children, and promotion of health education. According to its report for 1939-41 the Council has been giving advice and information on various matters pertaining to child welfare; it has established in Caracas, the capital, a day nursery-kindergarten for children of employed mothers; it has introduced foster-home placing of children; it supervises the work of an institution for wayward children; it provides meals for malnourished children from several schools. In all this work the Council is helped by a group of social workers. The Council has also made studies of tenement houses, school buildings, feeding of school children, and the economic and social situation of needy mothers.⁸

⁷ Mexico, Secretaría de la Asistencia Pública, Informe de Labores presentado al H. Ejecutivo de la Unión, 1940-41; Mexico, Departamento de Salubridad Pública, Los Servicios de Higiene Rural y Medicina Social, 1941.

⁸ Venezuela, Memoria y Cuenta del Ministerio de Sanidad y Asistencia Social (1940), Caracas, 1941; Informe del Consejo Venezolano del Niño, 1939-41, Caracas [1941].

NUTRITION

Interest in nutrition has been stimulated in the American Republics, as well as in other parts of the world, by the important studies of nutrition conducted in 1935-36 by the League of Nations.

Argentina.

The National Institute of Nutrition (Instituto Nacional de la Nutrición) is an outgrowth of the Municipal Institute of Nutrition of Buenos Aires which was taken over by the National Government in 1938 and reorganized as the National Institute of Nutrition. The Institute studies the problems of nutrition in health and disease and those of production, conservation, transportation, and consumption of food; it conducts a nutrition clinic and maintains a school with a 3-year course for training nutritionists; free tuition is available annually to several students from Argentina and other American countries. The Institute investigates the economic, social, and health conditions; it does preventive work by providing examinations for expectant and nursing mothers and follows the development of children from early infancy until the end of the school-attendance period.

Free food for expectant or nursing mothers and human milk for babies are distributed by the Institute. A combination out-patient clinic and hospital is maintained for diseases of nutrition; some patients come there for their treatment and meals while continuing at their work and sleeping at their homes; a hospital is attached for the care of acute cases and those requiring special observation. Periodic examinations of other persons are made, and advice on nutrition is given to them. Public lectures on feeding the family are given, and literature on this subject is published and distributed. The Institute maintains special dining rooms for well persons and for those needing special diets.⁹

Bolivia.

A Bureau of Nutrition (Departamento de Nutrición) was included in the Ministry of Labor,

Health, and Social Welfare of Bolivia organized in May 1941. The program of the new bureau, as described in the Boletín de la Oficina Sanitaria Panamericana for January 1942, calls for a census of the population, regular studies of food stuffs and food consumption, analysis of foods in the laboratory maintained by the Bureau, and the establishment of laboratories in other localities for the same purpose. The Bureau is also to supervise food production, to study the customary foods used by the native population, and to follow foreign legislation on these and related subjects.

The first studies undertaken by the Bureau relate to milk and to free lunches for school children.

Brazil.

The Social Insurance Nutrition Service (Serviço de Alimentação da Previdência Social) was established under a law of 1940 and reorganized by a decree-law of October 14, 1941. The main purposes of the nutrition service are (1) to promote the establishment and operation of workers' restaurants; (2) to educate the workers in the advantages of proper nutrition and the employers in the advantages of providing adequate and suitable food for the workers; (3) to supply food at reasonable prices to establishments providing meals for their workers; (4) to establish standards for meals in workers' restaurants; and (5) to organize practical courses in home cooking.

The money needed for the organization of the plan was lent by the social-insurance organizations, for whose members the plan is intended.¹⁰

Chile.

A Bureau of Nutrition (Departamento de Higiene de la Nutrición) was established in the National Department of Health (Ministerio de Salubridad, Previsión y Asistencia Social) in 1939. Low-price restaurants are functioning in Santiago.¹¹

⁹ Escudero, Dr. Pedro: La Política Nacional de la Alimentación en la República Argentina, Buenos Aires, 1939. 143 pp.

¹⁰ Diário Oficial, January 29, 1941; Legislação do Trabalho, November 1941.

¹¹ Boletín Médico de Chile, September 23, 1939, p. 1.

Colombia.

A decree of February 21, 1940, created the National Nutrition Council. Among the Council's duties are the following: To study the present diet and food habits of the people; to determine the most suitable dietary standards for the different parts of the country; to collect information about dietary studies already made in Colombia; to organize educational campaigns for the correction of wrong food habits; to study the influence of diet on health and the means of eliminating deficiency diseases; and to determine the diets to be adopted in the school lunch rooms and public low-price restaurants.¹²

Costa Rica.

A National Council on Nutrition (Consejo Nacional de Nutrición), a permanent agency of a technical and advisory nature, was established by a law of January 8, 1940, for study of the problem of nutrition and for proposing improvements in diets.¹³

Mexico.

The President of the Republic issued in 1939 regulations governing the composition and functioning of the National Commission on Foods (Comisión Nacional de Alimentación). The Commission was to study the problems of food and nutrition and to propose improvements.

The new President, elected late in 1940, is interested in improving the nutrition of the people. On December 2, 1940, he issued a decree providing for the establishment of "national dining rooms," where wholesome food is to be served at low prices to working people. The first dining room was opened in November 1941; it accommodates 1,200 persons who receive three meals daily for a moderate charge. The persons are selected among the low-income groups. Plans are made for the establishment of similar dining rooms in other crowded parts of the city.¹⁴

Peru.

A Bureau of Foods in Peru (Dirección Nacional de Alimentación) under the Ministry of Health has established lunch rooms for school children in various parts of the country. On October 31, 1941, the Bureau was replaced by the Departamento Técnico de Nutrición (Technical Bureau of Nutrition), also under the Ministry of Health. The "people's restaurants" and the Office of the Inspection of Free School Lunches and School Lunch Rooms were transferred from the Dirección Nacional de Alimentación to the Bureau of Social Aid and Welfare (Dirección de Asistencia y Previsión Social).¹⁵

Uruguay.

The Institute for the Scientific Feeding of the People (Instituto de Alimentación Científica del Pueblo) maintains public restaurants where adults and children are served meals at cost. These meals are prepared in accordance with the rules of nutrition, and the persons eating at these restaurants receive instruction in the proper selection of food.¹⁶

SOCIAL INSURANCE

A further manifestation of the growth of the social spirit in Latin America is the progress made in the field of social insurance, in which Chile, with its law of 1924, was the pioneer. Social insurance was given much prominence at the two regional International Labor conferences held in Santiago, Chile, 1936, and Habana, Cuba, 1939. In the last 6 years the Governments of several countries have asked the International Labor Office for help in drafting social-insurance laws; such laws were enacted in that period in Costa Rica, Ecuador, Panama, Peru, and Venezuela, while plans have been in preparation in other countries. In Argentina and Cuba maternity-insurance laws, although enacted in 1934, became effective in 1936 and 1937, respectively.

¹² Bulletin of the Pan American Union, August 1940, p. 603.

¹³ Índice General de la Legislación Vigente en Costa Rica el 30 de Abril de 1940 por Octavio Beeche, tomo cuarto, p. 2010.

¹⁴ Boletín de Sanidad e Higiene, vol. 2, No. 7, 1939; Asistencia, November-December 1941; El Popular, published daily in Mexico City.

¹⁵ Boletín del Instituto Nacional del Niño, January-March, 1941; La Reforma Médica, Lima, Peru, December 14, 1941, p. 784.

¹⁶ Instituto de Alimentación Científica del Pueblo, Ministerio de Instrucción Pública y Previsión Social, Montevideo, 1938.

Among the most important phases of social insurance as it affects children are sickness insurance and maternity insurance.

Sickness Insurance as Related to Child Welfare.

Sickness insurance, also providing for the care of maternity cases, is included in the laws of the countries named. It is compulsory for nearly all physical and mental workers with an income below a specified amount; those with higher incomes presumably do not need this form of social action. The benefits of sickness insurance have been extended in some of these countries to agricultural workers, who constitute a large part of the population and whose living and working conditions call for increased health protection. In some of these countries the law is still only partly operative; in Venezuela it has not been put into operation yet, and in Panama it applies temporarily only to a part of the country.

Insured persons, in return for their contribution of a small percentage of their wages or salaries to which the employers and the Government also add prescribed amounts, receive cash benefits in case of illness, medical treatment at home or in a hospital and in some countries preventive care. Members of the insured persons' families also receive medical care, including childbirth attendance and medicines, usually for a small additional charge.

Women insured in their own right receive medical attendance at childbirth and a part of their wages for a period of several weeks before and after childbirth, during which time their employment is prohibited by law. Little has been done toward adding prenatal care to the sickness-insurance benefits except in Chile, where the social-insurance system has been in existence since 1924, and insured women and wives of insured men receive during pregnancy periodic medical examinations, treatment, and the services of nurses and social workers.¹⁷

Maternity Insurance.

Maternity insurance is operating as an independent system in Argentina and Cuba. In

these countries maternity insurance is compulsory for women of child-bearing age employed in manual or clerical work, whether public or private. In addition, in Cuba every employed man is required to insure his wife or common-law wife if she is not employed. A percentage of the insured person's wage is paid into a national fund, with the employers and the Government adding specified contributions. In Cuba the women insured in their own right receive full wages for at least 6 weeks after childbirth; in Argentina, for 2½ months, partly before childbirth, partly afterwards. Their employment during these periods is prohibited by law, but their places must be kept for them by their employers. Periodic examinations during pregnancy and medical treatment before, during, and after childbirth are provided by law.

The experience of Europe where social insurance has stimulated care of children's health and efforts for the prevention of illness has been repeated in the American countries. Care of children's health is an essential part of the maternity-insurance program of Cuba. The insured mothers are required to bring their children under 2 years of age regularly to the health centers maintained in increasing numbers by the insurance organizations in various parts of the country; preventive care, treatment of illness, and instruction of the mother in child-care are given at these centers. The homes are visited to stimulate attendance at the centers and to ascertain the kind of attention received by the young children. Efforts along somewhat similar lines are reported to have been started in Argentina.

Preventive Work in Connection With Social Insurance.

Prevention of illness and disability, a duty assumed voluntarily in the past by the more advanced social-insurance organizations in Europe, is being gradually made available for the insured population in some of the American countries. In countries with maternity or sickness insurance preventive work is done mainly in the form of prenatal and child-health work. But the most original action was taken in Chile in 1938 with the

¹⁷ Mothers and Children under Social Insurance in Latin America, by Anna Kalet Smith. *The Child—Monthly Bulletin*, vol. 3, No. 12 (June 1939).

enactment of the law on "preventive medical service" which places on the insurance organizations the duty to take measures for the systematic protection of the health of the insured population.¹⁸ This law provides for periodic medical examinations for all insured workers in private or public service, including employed children, for the purpose of discovering latent disease, mainly tuberculosis, syphilis, cardiovascular diseases, and occupational diseases; also for the purpose of selecting workers in need of a preventive rest.

The examinations are made by boards of not less than three physicians, of whom one must be a specialist in tuberculosis. The examinations are compulsory and must be given at least once a year, and oftener when necessary.

The examining physician may order a partial preventive rest, and the employee is required then to abstain from work for half of each working day for a prescribed period; or he may order a complete rest. In either case the insurance organization pays the employee for the

time lost, as well as paying the cost of medical treatment. Before a decision is reached the worker's situation and that of his family are investigated.

During periods of partial or total preventive rest patients are under the observation of the physicians of the insurance organization to which they belong; they may not return to work without permission from the proper physicians. No employer may discharge a worker during the period of preventive rest unless there is a reason considered valid under the labor law. Every person concerned is required to comply with the law under threat of penalty.

The funds necessary to meet the cost of administering this law are derived from employers' contributions of 1 percent of their payroll and from special sums which the insurance organizations are required to set aside for this purpose.

In spite of the lack of enough physicians to examine all workers annually and the lack of sufficient hospital accommodations the value of this unique system is reported already to be evident.

¹⁸ Gaete Berrios, Alfredo; Código del Trabajo, Santiago de Chile, 1940. 720 pp.

NEWS NOTES

Inter-American Congress on Health of Chile hopes that the *Social Planning* Inter-American Congress on Social Planning, postponed from March 1942, can be held within a few months. The Congress, plans for which were originated by representatives of social-security and labor organizations at the conference in Lima, Peru, in 1940, is to be held in Santiago, Chile.

(Official correspondence of the Department of State with the Secretary of Labor.)

Inter-American Demonstration Centers About 25 Inter-American Demonstration Centers have been established in schools throughout the United States by the United States Office of Education in cooperation with the Coordinator of Inter-American Affairs.

The purpose of the demonstration centers is to develop a better understanding of other American Republics among children, young people, and adults. Some schools will accom-

plish this purpose through integrating the idea into existing courses, through developing new activities, through giving new and different emphasis to inter-American studies. Others will accomplish their purpose by introducing new courses into the curriculum, by setting up workshops, and by other means.

(U. S. Office of Education release.)

Inter-American Commission of Women The Inter-American Commission of Women, created at the Sixth International Conference of American States at Havana in 1928, held its second annual meeting at the Pan American Union in Washington, November 6-9, 1941. The Commission is composed of one delegate appointed by each of the 21 American Republics. After the delegates presented their reports of work during the year, the Commission adopted a number of resolutions. Among the resolutions were recommendations that "all governments which do not now provide them establish

nursery schools; establish obligatory courses in child care for girls in all secondary schools and higher educational institutions; establish schools for training voluntary domestic workers as an aid to civilian defense; coordinate educational standards to facilitate the interchange of students among the Americas; and pending enfranchisement of women, to admit them to public offices, to participation in juvenile courts, to advisory commissions to counsel legislative bodies on all subjects relating to women and children and also on subjects relating to education, and to admit them to diplomatic and consular services and to Pan American Conferences."

(*Information Bulletin No. 2, Inter-American Commission of Women, Pan American Union, Washington, D. C.*)

Bibliography of Pan American materials for children Our Neighbor Republics is the title of a selected list of readable books for young people issued by the United States Office of Education (Washington, 1912. 26 pp. Mimeographed). This bibliography contains reading material selected for furthering a better understanding of the Americas among children in the United States. Many of the books may be used with children of all ages but the reading level of each book is indicated in terms of school grades. Background

materials; nature; archaeology, arts, crafts, and poetry; and stories and legends about Latin America, are included.

New World Neighbor Series Worthy of mention in the New World Neighbor Series of books for children published by the D. C. Heath Co. (Boston, 1941, \$0.40 each) are the following:

LETTERS FROM GUATEMALA (56 pp.). This describes the life in Guatemala today. Colored illustrations supplement the text and a glossary contains the pronunciation of Spanish words.

RICHES OF SOUTH AMERICA (56 pp.). This contains stories about five South American countries concerning their home life, customs, and products. The text is supplemented by colored illustrations, and a glossary gives the pronunciation of Spanish words.

EXPLORING THE JUNGLE (56 pp.). The author describes her experiences in exploring the jungles of Venezuela, Colombia, and the Guianas and depicts Indian life in this region. Colored illustrations and a picture dictionary explain the text.

KIMBI (47 pp.). This is a story of the life and habits of the Jivaro Indians who live in the forests of southern Ecuador in South America. The text is explained by illustrations.

Pan American Day. April 14

• **BIRTH** •

• **GROWTH** •

• **CHILD HEALTH** •

Maintaining State Services for Crippled Children During the Present Emergency

BY A. L. VAN HORN, M. D.

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As is true with many public services, recent world events have influenced in a variety of ways the administration of State services for crippled children. One might cite, for example, the loss of various types of professional personnel including orthopedic surgeons, plastic surgeons, medical directors, public-health nurses, physical-therapy technicians, medical social workers and others; or the recent rationing program which has a direct and important bearing on transportation facilities for crippled children and those responsible for the supervision of their care and treatment; or problems connected with planning for the evacuation of children hospitalized in medical centers located in cities along our coasts.

Already many of the State agencies administering services for crippled children have encountered one or more of these problems, and it may be assumed that in the critical period ahead there will be still other problems to be faced and changes to be made in the administration of the State services.

Loss of Professional Personnel.

One present problem which appears to be affecting practically every State agency is the loss of professional personnel. According to present policies being followed by the Procurement and Assignment Service for physicians, dentists, and veterinarians, recognition is being given to essential services rendered by each physician in his community in determining whether he can serve more effectively in the

armed forces or within his own community. However, according to a recent announcement¹ issued by the Procurement and Assignment Service, all male physicians * * * under 45 are liable for military service and those who do not hold commissions are subject to induction under the Selective Service Act. Those who hold Army commissions are subject to call at any time and only temporary deferment is possible on approval of an application to the Adjutant General of the United States Army, certifying that the individual's services are temporarily indispensable. Physicians holding Naval Reserve Commissions are subject to call at any time at the discretion of the Secretary of the Navy. Temporary deferment may be granted only on approval of applications made to the Surgeon General of the Navy.

With the loss of various types of professional personnel whose services were being employed in the crippled children's program, it is apparent that certain changes will be necessary in the administration of the State services. The nature and extent of the changes required will depend largely upon the number, type, and qualifications of professional personnel who remain in the State. Various types of situations may arise with the continued loss of physicians, public-health nurses, physical-therapy technicians, medical-social workers, and others.

¹Procurement and Assignment Service for Physicians, Dentists and Veterinarians. *Journal of American Medical Association*, vol. 118 (February 21, 1942), pp. 625-649.

A. Physicians.

Several States have lost the services of medical directors who were members of the Medical Reserve Corps. In some instances it has been possible to fill these vacancies through the temporary employment of a qualified physician on either a full-time or a part-time basis. During a period when experienced leadership is greatly needed in meeting the difficult problems which will arise almost daily, it is extremely important that all such vacancies on the State staff be filled as promptly as possible.

It must be recognized that the services of certain medical specialists, particularly those with training and experience in fields such as general surgery, orthopedic surgery, and plastic surgery, are likely to be sought by the armed forces. In one State the only orthopedic surgeon in the State has been called up for active duty and this has necessitated revamping the entire State program of services for crippled children. In another State the only plastic surgeon in the State has been called up for active duty, and the State agency has decided not to accept children requiring plastic surgery for care, since there is no qualified plastic surgeon in any of the adjoining States whose services might be used.

B. Public-health nurses, physical-therapy technicians, medical-social workers and other types of professional personnel.

Almost without exception, every State crippled children agency has now experienced the loss of some member of its professional staff to the Army, the Navy, or the American Red Cross. It is fortunate that these trained professional workers can be of assistance during this critical period. However, in several instances the loss of such personnel has seriously jeopardized those particular phases of the State programs and replacements are often difficult if not impossible. Before such persons volunteer their services in the armed forces or the Red Cross, they should give thought to the equally valuable and patriotic service which they can render in essential programs for the protection and promotion of health among the civilian population.

It is apparent that with the loss of public-health nurses on State and local staffs, State agencies will have to develop procedures whereby greater utilization than heretofore will be made of local health and welfare personnel and the services of local voluntary groups.

With the decrease in the number of professional personnel within the States, it is important that State agencies carefully review their State programs and make provision for adjustments that will tend to utilize in the most efficient manner the services of those who remain.

Questions have arisen regarding changes in qualification standards for the selection of med-

ical specialists. Nothing will be gained by lowering the standards of care. If no qualified orthopedic surgeon remains in the State, children requiring operative care by an orthopedist either should be transported to an adjoining State for care and treatment by a qualified orthopedist or should not be accepted for care.

However, if one qualified orthopedist remains in the State, it may be possible to continue a satisfactory program by using the services of qualified general surgeons for selected cases under the general supervision of the orthopedic surgeon. It is recognized that there are certain types of crippling conditions, such as acute chronic osteomyelitis and compound fractures, which are classified as orthopedic defects but which may be treated satisfactorily by competent general surgeons. If the selection of cases could be made by the orthopedic surgeon and the plan of treatment carried out under his general supervision, it would seem feasible to utilize the services of qualified general surgeons for such cases. State agencies may wish to bring this problem to the attention of their technical advisory committees for consideration and recommendations.

In some States it may be necessary to curtail the number of children to be accepted for care. If so, all cases should be classified as to urgency of need for treatment services so that those in greatest need will be served first.

Transportation Problems.

Another phase of the Nation's all-out effort which has affected every State program is the recent rationing of automobile tires. It appears now that if the tire-rationing policies are changed they may be even more restrictive unless some satisfactory substitute for rubber is developed. Until such time, however, it is obvious that transportation services for crippled children will present one of the most difficult problems confronting the State agencies. Families that heretofore have been able to take their crippled children to clinics, hospitals, and convalescent homes may now be unable to do so because of inability to obtain tires for their cars. If they can use their cars, they may be reluctant to travel long distances to and from urban medical centers. On the other hand,

physicians, nurses, and other health workers engaged in providing direct medical and health services to the civilian population are given priority in obtaining tires. It is apparent, therefore, that the logical procedure is for the State agency to extend and improve the field clinic services whereby the professional personnel can conduct clinics nearer the home of the child.

In considering this solution, State agencies must also keep in mind that fewer orthopedic surgeons and other specialists will be available for conducting such clinic services. Those who remain in their communities will undoubtedly be busier than they were previously. However, by more careful selection of children to attend clinics and by improved clinic procedures, it is believed that even the busiest orthopedic surgeon will be glad to cooperate in conducting clinics in outlying districts. The success to be attained in bringing about more efficient services for crippled children during this critical period depends almost entirely upon the resourcefulness of the State agency in utilizing the facilities and services available.

Availability of Hospital Facilities.

Many hospitals in urban centers where large defense industries are being developed or are now in operation have experienced difficulty in meeting the needs of the community for hospital beds because of the rapid increase in population in these areas. It may be necessary in such instances for the State agency to use greater care in the selection of children to be hospitalized or to explore the possibility of using other hospitals in other communities in the State where the needs for hospital beds are not so pressing. In any event, the State agency should assure itself that desirable standards of care will be maintained in whatever hospital is to be used for crippled children.

Problems of transportation and the potential if not actual shortage of hospital beds again bring into focus the need for more convalescent facilities for crippled children. In no State are such facilities adequate to meet the needs. In defense areas where needs have become even more acute because of the rapid increase in population, consideration can be given to the

construction of convalescent homes under the provisions of the Community Facilities Act (Lanham Act). The need for such institutions should be discussed with the appropriate State and local agencies before such a request is submitted through the regional office of the defense health and welfare agency. There can be little doubt that with convalescent facilities and with the use of approved foster homes many crippled children could be provided with care and treatment which they might otherwise be denied.

Evacuation of Crippled Children From Institutions in Coastal Areas.

No one can predict accurately what will happen during the critical period ahead. The possibility is generally recognized, however, that coastal areas may be attacked from the sea or the air. Consideration should be given by State agencies to plans for the evacuation of crippled children from hospitals and other institutions to areas where they will be comparatively safe. Such plans, of course, have already been considered in many coastal cities as a part of the general plan for evacuating all hospital patients. In coastal communities where such plans have not been fully formulated, they should be completed. Facilities in inland areas should be carefully explored and the necessary arrangements made so that if necessity requires, the evacuation can be carried out satisfactorily without confusion or loss of life.

The State agencies administering services for crippled children should assume responsibility for participating in the development of plans which involve the removal and placement of crippled children who are under the care of the agency. Plans should, of course, include provision for metal identification tags for all crippled children in hospitals and institutions and for contact with the child's family. Some children in the hospital may be able to return to their own homes. Others will require foster-home care, and still others will need continued hospital care. These needs should be known to the State agency and current information should be available as to the placement and status of all children not in their own homes. The families of some children who are in their own homes

may need assistance and advice in making plans for removal of a crippled child who is unable to move about unassisted.

Vocational Rehabilitation of Crippled Children of Employable Age.

On January 26, 1942, a letter from the Children's Bureau was directed to all State agencies administering services for crippled children, informing them of the recent appointment at the direction of the President of an Interdepartmental Committee to consider problems relating to vocational-rehabilitation services for members of the armed forces who have become physically handicapped, for members of the civilian population handicapped in the course of the Nation's all-out effort, and for persons injured while employed in defense industries. This action is of the utmost importance at this time in the conservation and most effective use of the Nation's manpower. State agencies have been urged to review at this time the State register of crippled children and the present case load to determine whether or not there are any children of employable age on the register who should be referred to the State vocational-rehabilitation service for training. The following recommendations were made:

1. That State agencies administering services for crippled children and State vocational-rehabilitation agencies develop methods of joint planning for considering the problems of individual physically handicapped children, and the action to be taken with special reference to physical restoration, social adjustment, vocational guidance, vocational education, and placement in industry. It is considered that such joint planning is preferable to the practice frequently followed of routine referral of physically handicapped children of employable age to rehabilitation agencies.

2. That State agencies administering services for crippled children and State vocational-rehabilitation agencies develop plans for the periodic review of cases of children with physical handicaps who are under care in order to consider whether all children who can

benefit from training for employment have been referred to the State vocational-rehabilitation service; to evaluate the correlation of the services provided by both agencies to individual children; and to work out methods for improving such services to meet the needs of individual crippled children.

3. That State agencies administering services for crippled children and State vocational-rehabilitation agencies have a mutual understanding of their respective services and cooperative policies, preferably in the form of a written memorandum prepared jointly which will include provision for free exchange of information regarding any physically handicapped person under 21 years of age, attendance of rehabilitation worker at diagnostic clinics held for crippled children, and provision for regular and planned case-study conferences between representatives of such agencies in developing plans for individual children.

4. That special consideration be given by State agencies to problems concerned with the physical restoration and vocational rehabilitation of youths under 21 years of age who may be rejected for general military service because of a physical handicap or discharged from the armed forces with a physically handicapping condition resulting from injury, accident, or disease.

Since the transmittal of this letter, numerous replies have been received describing the steps which are now being taken to bring about more effective joint planning by State agencies so that this potential source of essential manpower can be utilized to the best advantage. Several State agencies are arranging a series of special conferences to consider the problems of individual children of employable age, with particular reference to completion of physical restoration, mental and physical capacities, and vocational aptitudes. Continued efforts are needed in this direction.

It is apparent the State crippled children's agencies face a period when many new and difficult problems must be met and solved. It will require all the ingenuity and resourcefulness of the State staff to utilize most effectively the existing facilities and services within the State in the best interests of the crippled child.

May Day—Child Health Day. May 1

Organization of Child-Health Conferences, Prenatal Clinics and Home-Delivery-Nursing Services in Indiana¹

By HOWARD B. METTEL, M. D.

Chief, Bureau of Maternal and Child Health, Indiana State Board of Health

The Bureau of Maternal and Child-Health of the Indiana State Board of Health for the past few months has been actively engaged in the establishment of child-health conferences, prenatal clinics, and home-delivery-nursing services in many counties of the State. This activity has resulted from local requests for services in the presence of the national emergency.

The need of a preventive medical-care program for the mothers and children of Indiana is realized now more than ever before. Likewise, many physicians are aware of the shortage of doctors which will result after many of the younger men are called into active military service. These physicians realize that there will be a very definite increase in the case load. In many instances the older groups of practicing physicians will be asked to carry on the medical-care program of the civilian population. These men, therefore, realize that if they are to promote a preventive medical-care program it will have to be done on a group or clinic basis. With properly organized and administered health conferences, the practicing physicians will not only be able to see a great many more cases, but will be assisted by a trained staff of professional and volunteer workers.

These health conferences are to be administered strictly on a preventive-care basis and are not to be confused with clinics which diagnose and treat the sick mother or child. The medical care of the sick should be the responsibility of the private physician in his own office, with a strictly patient-physician relationship. These conferences are to be educational and instructive. They are to carry to the civilian population our present knowledge of such subjects as

nutrition, growth and development, good health habits, and other valuable health information that many Indiana mothers and children are not receiving. This is especially true in the rural areas and in the overpopulated defense centers which now have been established throughout the State of Indiana.

The organization of health conferences for mothers and children is not a new idea. These conferences have been operated successfully in many of the metropolitan areas of the State for a number of years. The results of the operation of this type of health service are shown by a study of the morbidity and mortality rates of mothers and children during the past 15 years. Indianapolis has and does operate 14 child-health conferences, 6 county child-health conferences, and 9 prenatal clinics—not including those in operation in the private and public hospitals of the city. Elkhart, Terre Haute, South Bend, and Evansville have operated this type of health program for many years. Indiana has lagged in the establishment of this type of health conference, especially in the rural areas and the smaller towns where the health needs of mothers and children are as great as in the metropolitan centers. The surrounding States of Kentucky, Illinois, Michigan, and Ohio during the past 5 years have established large numbers of health conferences in the rural areas.

The Bureau of Maternal and Child-Health of the Indiana State Board of Health, anticipating these needs and demands, especially from the defense areas, has formed a competent professional staff of consultants to assist local groups and county medical societies in the formation and administration of these new services. The Indiana State Board of Health is prepared to assist any local areas or groups in establishing these services, with the request that the services be operated by the local phy-

¹Reprinted by permission from *Journal of Indiana State Medical Association*, vol. 35, no. 3 (March 1942), pp. 163-164.

sicians and personnel who are particularly interested in the fields of preventive pediatrics and obstetrics. The Indiana State Board of Health has funds for the payment of the part-time services of physicians conducting these local conferences.

The initiative for the creation of these conferences should rise in the local community. A local group, such as the county medical society, a service club, a parent-teacher club, or any other group interested in the promotion of better maternal and child health should sponsor the local programs.

Refresher courses and field visits to establish conferences will be offered to all physicians who wish to participate in this program. Many excellent and well-qualified practicing physicians, with the exception of those limiting their practices to pediatrics, have had very little experience in the health supervision of the well child. It will, therefore, be to the advantage of those physicians to avail themselves of these refresher courses and field demonstrations.

The equipment and housing of these conferences need not be elaborate or costly. They are comparatively inexpensive to operate. The success of these health projects depends en-

tirely upon the full-fledged cooperation of local physicians, public-health nurses, and the aid and support of some volunteer lay groups.

Any medical society or local group interested in the formation of these health services in local areas will be assisted by the Bureau of Maternal and Child-Health of the Indiana State Board of Health. Seven county medical societies are now negotiating with the Bureau for the establishment of a child-health conference or prenatal clinics. These counties will soon have such services in full operation. It is anticipated that within the next year all defense areas and all district health departments will have established child-health conferences and prenatal clinics.

Further extension of the maternity-nursing services, such as those which are now successfully operating in six counties of Indiana, cannot be expected to be established in the near future due to the inability to recruit qualified maternity nurses. Four requests for additional maternity-nursing services are now on file in the offices of the Indiana State Board of Health. Supplies have been purchased, and these services are expected to begin operation as soon as qualified maternity nurses can be secured.

BOOK NOTES

A STUDY OF HEALTH AND PHYSICAL EDUCATION IN COLUMBUS PUBLIC SCHOOLS, by T. C. Holy and G. L. Walker. Ohio State University Studies, Bureau of Educational Research Monograph No. 25. Ohio State University, Columbus. 1942. 240+xvi pp.

This book reports a survey of the health problems of the school system of Columbus, Ohio. The study was made for the Columbus Board of Education by the Bureau of Educational Research of Ohio State University in cooperation with the health committee of the Columbus Board of Education, the Columbus Dental Society, the State Department of Education, and the Commission for the Blind. There are four major headings: Healthful School Living, Health Services, Health Instruction, Physical Education and Recreation.

The report analyzes in considerable detail the engineering, administrative, and clinical aspects of the school health problems in Columbus, and makes specific recommendations in regard to improving existing conditions.

EYE CONDITIONS AMONG PUPILS IN SCHOOLS FOR THE BLIND IN THE UNITED STATES, 1939-40; a report for the Committee on Statistics for the Blind, by C. Edith Kerby. *Outlook for the Blind* (American Foundation for the Blind, 15 West Sixteenth Street, New York), Vol. 36, No. 1, pp. 16-24 (February 1942).

Causes of blindness as shown from records of ophthalmological examinations of pupils in schools for the blind show that about one-fourth (23.8 percent) of blindness in children is due to infectious diseases. Of these, ophthalmia neonatorum is still the most important (10.6 percent of the total), with syphilis, meningitis, and trachoma also mentioned.

Traumatic injury is stated to account for 8.0 percent of the blindness among children. Neoplasms, particularly brain tumors, are responsible for 2.8 percent and general diseases, including nutritional deficiencies, for 1.2 percent. Nutritional deficiencies may have contributed somewhat to the outcome in many cases attributed to other causes.

The largest group of cases (51.4 percent) are stated to be of prenatal origin.

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Child Labor in Arizona Cotton Fields

By EDWIN E. VALLON

Industrial Division, Children's Bureau

During the fall of 1941 members of the Children's Bureau staff were sent to Arizona to investigate the employment of young children in the cotton fields. Only 80 of the thousands of cotton farms in the State were visited, but on these 80 farms 255 children under 16 years of age—many of them under 10 years—were found working as cotton pickers.

The employment of children in agriculture has long been recognized by the Children's Bureau as presenting a major problem in the enforcement of the child-labor provisions of the Fair Labor Standards Act of 1938. The fact that the minimum-age standards of the act apply to children employed in agriculture only during those periods when they are legally required to attend school presents innumerable difficulties in administration, as compulsory-school-attendance laws vary considerably from State to State.

Much of the agricultural child labor of today is different from what it was when children worked mainly for their own parents on the home farm. The work of children in industrialized agriculture is not the educational process of the parent initiating his child into tasks that are an integral part of the traditional farm life. On the contrary, it is highly commercialized, nearly always hard, repetitive labor characterized by long hours and unsuitable and often hazardous conditions of work, subject to competitive pressure. More particularly, agricultural labor is characterized to a high degree by migrancy, by low incomes, and by poor living conditions.

Young children employed as agricultural laborers have been found to suffer from ill health

and from a lack of educational opportunities and wholesome recreational outlets.

The investigations in Arizona not only were made to determine compliance with the existing child-labor provisions but also were planned as an experiment to determine the extent to which the agricultural coverage provided by the Fair Labor Standards Act is enforceable and to work out techniques for enforcement. The findings of the investigation amply substantiated preliminary reports from various sources that large numbers of children under 16 years, the basic minimum age for employment under the act, were employed as cotton pickers under such adverse conditions as to affect seriously their health, education, and general well-being.

Cotton growers in Arizona depend to a large degree upon a migrant or semimobile supply of labor to meet the seasonal peaks of the cotton harvest. Cotton picking begins as early as August, when a small acreage of stub cotton matures, and continues as late as February. The harvesting peak, however, occurs during the months of October, November, and December, and it is at that time that the influx of migrant families reaches its high point.¹

Inspections were begun in Arizona by members of the Children's Bureau staff late in October 1941 and continued through the first week in December 1941. It was immediately evident that it would be impossible with the limited staff available to inspect every farm or ranch in the State on which cotton was grown. In Maricopa County alone, 2,000 cotton growers

¹ Migratory Cotton Pickers in Arizona, p. 54. Works Progress Administration, Washington, 1939.

are listed with the county agricultural-adjustment committee. Every effort was made, therefore, to spread inspections throughout the counties in which cotton is grown so as to check for child labor in picking crews over as wide and diversified an area as possible. The 80 farms covered in the investigation were located in 5 counties.

The 255 children under 16 years of age found working as cotton pickers were on 58 of these 80 farms, all of which delivered their cotton for shipment in interstate commerce. Their ages, which ranged from 3 to 15 years, were as follows:²

Age of children	Number		Percent
	Total	255	100.0
Under 6 years.....	18	7.1	
6 and 7 years.....	16	6.3	
8 and 9 years.....	28	11.0	
10 and 11 years.....	44	17.2	
12 and 13 years.....	61	23.9	
14 and 15 years.....	88	34.5	

Of this group 167 (65 percent) were under 14 years of age and 106 (42 percent) were under 12 years of age. The children were all working while school was in session.

Under the child-labor provisions of the Fair Labor Standards Act, children may be employed in agriculture except when legally required to attend school. In Arizona the school law provides that all minors between the ages of 8 and 16 shall attend school unless they have been excused by the district board of trustees and the county school superintendent for one or more of the reasons outlined in the statute. These reasons include exceptions for children receiving competent instruction at home or in private schools, for children physically or mentally incapacitated, for those who have completed the grammar-school course or who are over 14 and legally employed, and for children who present any other satisfactory reason for nonattendance.³

None of the 221 children between 8 and 16 years of age working during school sessions had presented school-leaving excuses in writing. All were considered, therefore, to be employed con-

trary to section 13c of the Fair Labor Standards Act. The remaining 34 children were all under 8 years of age and were legally employed under the act since their attendance was not required by the Arizona school law.

More than twice as many boys (172) as girls (83) were found picking cotton, since household duties fell more frequently on the girls. It was usually a daughter who had to take care of her younger brothers and sisters and in many cases assist with the cooking and washing. For these reasons girls were frequently found at the family camp site or in the family "jalopy." Members of the Children's Bureau staff on many occasions found a little girl seated inside the family car, with all the doors and windows shut, trying to take care of a brood of three or four children younger than herself. Where parents were unable to make even this provision for the care of their very young children, the children remained in the field during the entire working day, toddling along with the family pickers. Investigators found children as young as 3 years at work carrying their own small cotton bags.

Picking cotton is not easy work. It involves a considerable amount of bending and stooping. In many cases children drag cotton bags 9 to 12 feet in length while picking. As the bags fill, their weight increases so that children were frequently found dragging bags heavier than themselves. Children were also seen dragging bags which weighed from 40 to 75 pounds up a high ladder in order to empty the cotton into the "weigh wagon."

The hours of work in the field are long, and many children were found who worked from breakfast to supper without any food. Twenty percent of the 255 children reported that they had worked 9 to 11 hours on their last full day. Thirty-nine percent had worked between 8 and 9 hours, and 28 percent had worked from 6 to 8 hours. The remaining 13 percent did not give sufficient data regarding their hours of work to permit tabulation.

Although these inspections were made primarily for the purpose of determining the adequacy of the child-labor provisions of the Fair Labor Standards Act and the extent to which they are complied with, the members of the Children's Bureau staff were able to secure,

² Two of these children had alleged that they were 16 years of age but were found to be only 15 years when ages were verified by bureaus of vital statistics.

³ School Laws of Arizona for 1941, sec. 54-505

at the same time, a considerable amount of pertinent information concerning each child's racial background, his status as migrant or resident, and the last school grade he had completed.



The children found working at cotton picking were both from families resident in Arizona and from families migrating from outside the State. The migrant group of child workers was slightly larger than the resident group. Of the 255 children under 16 years for whom schedules were obtained, 151 (59 percent) were members of families migrating from outside the State and 104 (41 percent) were members of families resident in the State for a period of at least 1 year. Eighty-four percent of the children of both the resident and out-of-State families were white, 13 percent were Negro, and 3 percent were Indian.⁴

Of the white children the residents were predominantly of Mexican or Spanish-speaking

heritage, whereas most of the migrants were of non-Spanish-speaking ancestry. Sixty-five percent of the children of resident families were of Spanish-speaking origin as compared with only 18 percent of the children of the out-of-State families.

Without exception, the entire group of 255 children under 16 found working in the cotton fields were reported to have been born in the United States. The resident children were born within a group of 5 neighboring western States; the birth places of the out-of-State children were scattered throughout 18 States, mostly in the West and South.

Many of the families resident in Arizona were found to migrate from their homes within the State to the cotton fields. The economic pressure of low incomes frequently impelled them to move from place to place within the county and sometimes from county to county in their search for work. Children of resident families picking cotton, therefore, are confronted with problems of insecurity and intermittent school attendance similar to those which face children in families migrating long distances from State to State.

Families engaged in picking cotton were usually found living at camps provided by the growers. Many of these camps consisted of small canvas or wooden shelters, some with dirt floors. As many as eight individuals, including parents, relatives, and children, were found crowded into one of these small tents. Sanitary standards were at a minimum. Some camps had running water piped to a central point in the camp. In others a nearby irrigation ditch proved to be the only water supply available.

After a heavy rain the camp grounds would become a sea of mud. During late November and December, when the weather is rainy and the nights cold, suffering is often acute. Small stoves sometimes found inside the shack were hardly adequate to heat the flimsy, drafty shelters.

Most camps were located in sparsely settled areas, many miles from the nearest town or village. Recreational opportunities both for children and for adults were almost entirely lacking. None were found at the camps in

⁴ Figures given in regard to Indians cannot be considered representative since they do not include additional Indian children who were found picking cotton and for whom no schedules could be completed. This was due to the shyness of the children and the extreme reluctance of the parents to give information.

which the pickers lived. At best, children could look forward only to a Saturday afternoon and evening at the nearest town when the family food purchases for the week were made. If the earnings for the week were particularly good, the excursion might include a motion-picture show.

Problems of Schooling.

Thirty-seven district and county school officials were interviewed by the Children's Bureau investigators during the period covered by the inspections. Almost without exception, these officials reported greater difficulty in enforcing the compulsory-school-attendance laws during the cotton picking season among the families migrating for cotton picking from outside the State than among the resident group. Of the 128 out-of-State children of school age, i. e., between 8 and 16 years, 80 percent reported that they had not enrolled in school during the fall term of 1941. Forty-four percent of the 93 resident children of school age reported non-enrollment. A child of either group was considered enrolled if he stated that he had reported to school and registered during the fall term of 1941.

In this respect it was significant that there was keen interest displayed by many Arizona school people in trying to get into school the children of families coming from outside the State. They felt that the schools had something to offer the children even if they attended for only a short period of time. One school official pointed out that some of the migrant children have never learned how to play. He told of two boys of 14 who came to school one day and who did not know how to throw or catch a ball and had never participated in group games. He also pointed out that some of the older boys and girls among the migrant children have fallen so far behind in their schooling that they rebel against attending classes where they have to sit with the "babies."

School officials complained in many districts that considerable difficulty was encountered in attempting to locate migrant families and that by the time the children were discovered by the local attendance officer, their families were preparing to move to another district. An instance

was given of a girl who was reported to have been enrolled in 11 schools in the State during the 1940 cotton-picking season. The fact that most of the school districts in rural areas were relying upon the school bus driver to act in the capacity of attendance officer in addition to his driving duties seriously handicapped effective enforcement of the school-attendance law.

The great extent to which the working children of both resident and migratory families are deprived of educational opportunities is shown in the information which was obtained on the school grade completed at the time of their most recent attendance. Of the 61 children 12 and 13 years of age, 20 percent had completed only the second grade or less, and 64 percent had completed only the fourth grade or less. Moreover, of the 88 children 14 and 15 years of age, 10 percent had not advanced beyond the second grade and 44 percent had completed only the fourth grade or less. The fact that a child who entered the first grade between his sixth and seventh birthdays and progressed normally in school would complete at least the fourth grade at 11 years of age indicates the deficiency in the education of many of these working children. Thus a normally intelligent boy of 14 who had completed only the second grade could be said to have been cheated of the equivalent of 5 years' schooling.

It must be realized also that although some of the working children were currently enrolled in school and might therefore be expected to progress further, the larger number of children were not enrolled and many were unlikely to receive much additional education. One rural school principal told the Children's Bureau representative that in 1940 she had in her school for 1 day a boy of 14 who had come with his family to Arizona from Oklahoma to pick cotton, and that he had never been in school before in his life.

The experience of the Children's Bureau in making these inspections shows that the present coverage of the child-labor provisions of the Fair Labor Standards Act does not reach all the children hired to work in the Arizona cotton fields during school hours. Thirteen percent of

all the children under 16 who were found picking cotton fell in the group under 8 years of age and were thus too young to come under the Arizona compulsory-school-attendance requirements.

It is evident that the education of many children in Arizona is being interfered with to a serious degree through their employment as cotton pickers and that the conditions under which these children and their families work and live are not such as to safeguard their health and well-being.

Increased demands for the services of chil-

dren will undoubtedly be made as the war effort progresses and the need for agricultural labor increases. It is to the best interests of the Nation to insure the health, education, and well-being of all children during the trying years to come, and so far as possible to avoid the labor of children under 16 during school terms, as found in Arizona in this investigation. Only through the effective protection of all its children today and tomorrow will the Nation have the informed, healthy, and capable citizens it will need for the hard job of winning the peace with democracy.

Hearing on Proposed Hazardous-Occupations Order on Radioactive Substances

A public hearing was held on March 25, 1942, in the Labor Department Building in Washington, D. C., on a proposed order declaring occupations involving exposure to radioactive substances to be hazardous for minors and setting a minimum age of 18 years for employment in such occupations.

The order will become effective May 1, 1942. This is the sixth hazardous-occupations order issued by the Chief of the Children's Bureau under the child-labor provisions of the Fair Labor Standards Act of 1938. With the increasing pressures of war production and the employing of greatly increased numbers of 16- and 17-year-old boys and girls in war production industries, this order has special significance. It is the first to be issued by the Children's Bureau in the health field and the first to be issued since the entrance of the United States into the World War.

Exposure to radioactive substance occurs in the manufacture of self-luminous compound (radium paint); in its use when applied to the numerals and hands of watches, clocks, and instruments, or to buttons and other miscellaneous articles; and in the processes of incandescent-mantle manufacture. Anemia, damage to bone tissue, and skin lesions are among the harmful effects of excessive exposure to

radioactive substances, and a number of deaths have been caused by radium poisoning.

The hazards are greater for young persons than for adults because young persons are not so likely to possess the qualities of carefulness, neatness, forethought, and attention to personal hygiene that are essential in the observance of safe practices.

The order covers all work in workrooms in which radium is stored or used in the manufacture of self-luminous compound; in which self-luminous compound is made, processed, or packaged; in which self-luminous compound is stored, used, or worked upon; or in which incandescent mantles are made.

The findings on which the order is based are the result of careful investigation of occupations involving exposure to radioactive substances and of consultation with industrial hygienists, physicists, and employers. These findings are contained in a report, *Occupational Hazards to Young Workers: Radioactive Substances*, which is available on request from the Children's Bureau.

Employers may protect themselves against unintentional violation of the order by obtaining employment and age certificates from issuing officers in their States for employees claiming to be 18 and 19 years of age.

The order applies only to employers covered by the Fair Labor Standards Act of 1938. The minimum-age standards of the State child-labor law prevail in the case of employers not covered

by the act, and also in the case of employers who are covered by the act wherever the State standard is higher than the standard set by the Federal law.

BOOK NOTES

YOUTH AND THE FUTURE. General report of the American Youth Commission, American Council on Education. Washington, 1942. 206 pp. \$2.50.

Youth and the Future is the general report of the American Youth Commission, which was established by the American Council on Education in 1935 to conduct a comprehensive investigation of the problems facing youth. The stated purpose is "to set forth a program in regard to youth—a program based on the experience of the past, adjusted to the harsh realities of the present, and adequate to foreseeable needs of the future." The report is based on studies made throughout the last 6 years and extending into the period after the declaration of war.

The comprehensive nature of the report is indicated by the statement in the introduction that "as we shifted our attention from one aspect of youth to another, taking up questions in the fields of secondary education, use of leisure time, marriage and the home, health and fitness, juvenile delinquency, citizenship, and the special problems of rural youth and of minority groups, we found ourselves meeting the economic situation at every turn. Through this process it became apparent that major attention must be given to the problem of employment opportunity for youth in all of its manifold ramifications."

The Commission has defined the period of youth as that extending from 12 to 24 years of age and has studied the varying problems affecting persons within this age range, although its primary concern has been with the 16-to-21-age group. The report states: "The special social obligation to youth under 21 can be met mainly in three ways: by providing schooling, by efforts to expand normal employment opportunities, and by appropriate programs of public work."

In reference to education, the report recommends a realistic reorganization of secondary education in relation to content, and to the proper recognition of the levels of development and maturity in the several age groups. The report proposes that provision be made for the financial needs of pupils by arranging for the paid employment of all students as a part of their training, and for tuition-free education through the junior-college period.

For youth work programs, the Commission recommends: "Within the age limits specified, there should be no requirement as to relief status or financial need. One of the major reasons for providing youth work programs is to make certain that young people will be able to obtain the maturing experience of employment

at the right stage in their personal development. The need for this experience is not confined to youth in low-income families. On the contrary, many sons of wealthy parents have a special need for the type of experience they would obtain in the Civilian Conservation Corps, and it would be equally desirable to provide opportunity for the daughters to participate in a program from which they would derive similar benefit."

The Commission reports on conditions of child labor that "despite great progress in public appreciation of the necessity of putting a stop to oppressive child labor, there are, nevertheless, many thousands of instances where children of tender ages are subjected to long hours of harmful drudgery. In many cases irreparable injustice is being done, especially when the labor of the child interferes with regular school attendance."

Comprehensive recommendations are also made concerning training for citizenship, recreation programs, health and fitness, especially in relation to the development of a health-insurance program, and the correction of the social and individual conditions which cause antisocial conduct on the part of youths.

The major premise of the Commission might well be expressed by quoting the following: "In the future we shall not be allowed to say that young people are to achieve life and liberty only by struggling successfully as individuals from a morass for which we are all economically, politically, and morally responsible. Our responsibility for action is clear. In some field of labor, private or public, at all times opportunity must be provided for young people to work in a manner commensurate with their powers, with a return sufficient to sustain life and the institutions of marriage and the home, and to secure advancement in responsibility and in the esteem of their fellow citizens."

I. L. C.

3,800 CHILDREN OUT OF SCHOOL. A study made by the City Welfare Department and the Research Bureau of the Council of Social Agencies with the assistance of the Work Projects Administration. Dallas, Tex., January 1942. 17 pp.

This report of a survey made in Dallas shows 3,800 children between the ages of 7 and 15 years not enrolled in school in October 1940. Economic and other needs of children are pointed out as primary causes of failure to attend school. Federal regulation of child labor and certain educational objectives are advocated with a view to increasing school attendance.

• **EVENTS OF CURRENT INTEREST** •

Campaign for Early Diagnosis of Tuberculosis

On April 1 the National Tuberculosis Association opens its annual educational campaign for early diagnosis of tuberculosis. The theme for 1942 is Tuberculosis—Find It, Treat It, Conquer It. Program material, which may be

obtained from the National Tuberculosis Association (1790 Broadway, New York), includes three pamphlets: *Element'ry, My Dear Holmes*, *Element'ry* (on case finding); *If It Happened to You* (on treatment); and *Keep 'em Flying* (on eradication).

CONFERENCE CALENDAR

Apr. 21-23	New England Public Health Institute, Providence, R. I.	May 6-9	National Tuberculosis Association. Thirty-eighth annual meeting, Philadelphia.
Apr. 27-May 1	National League of Women Voters. Biennial conference, Chicago.	May 7-9	National Probation Association. New Orleans.
Apr. 30-May 2	American Pediatric Society, Skytop, Pa. Secretary: Dr. Hugh McCulloch, 325 North Euclid Avenue, St. Louis.	May 10-16	National Conference of Social Work. Sixty-ninth annual conference, New Orleans.
May 2-9	Eighth Pan American Child Congress. Washington, D. C. See p. 255.	May 18-23	Biennial Conference of Nursing Organizations, Chicago. (National organization for Public Health Nursing, American Nurses' Association, and League for Nursing Education.)
May 4-9	National Congress of Parents and Teachers. San Antonio, Tex.	June 8-12	American Medical Association. Ninety-third annual meeting, Atlantic City, N. J.
May 5-8	International Association of Public Employment Services. Louisville, Ky.	June 21-25	American Home Economics Association. Thirty-fifth annual meeting, Boston.
May 6-7	Association of Juvenile Court Judges of America. Annual conference, New Orleans.	June 21-27	American Library Association. Sixty-fourth annual conference, Milwaukee.
May 6-8	National Council of State and Local Welfare Administrators. New Orleans.		

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

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The

CHILD

*** Monthly Bulletin ***

Factors in Planning Community Day-Care Programs

* * *

Washington Trains Volunteers for Day Care of Children

* * *

Special Certificates of Birth Registration for Adopted Children

* * *

Public-Health Services in the Clark County Defense Area

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Health Services in Hawaii

* * *

General Advisory Committee on Protection of Young Workers

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

MAY 1942



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UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF

Factors in Planning Community Day-Care Programs

BY EMMA O. LUNDBERG

Director of Special Projects, U. S. Children's Bureau

WHY ARE FACTS NEEDED?

COMMUNITY programs for day care of children of mothers employed in defense areas should be planned so that they will meet actual needs as economically as is consistent with good standards of service. Day care is a serious venture in child-welfare services and should not be undertaken by sporadic groups whose activities are not related to a coordinated community plan.¹ As a wartime measure, women with young children should be enabled to do work for which they are urgently needed in war production or in other occupations essential to the national defense without sacrificing the health and welfare of their children. Provision of day care is a measure of very great importance in defense areas where a real need exists for employment of all available women, including those with household responsibilities.

The first requirement in planning for a community day-care program is to have a clear understanding of the function of day care in relation to the present emergency. Provision for the day care of children whose mothers are employed in defense industries or in other occupations necessary for the national defense must be planned on the basis of existing and prospective needs of school-age as well as pre-school children of mothers who cannot otherwise make suitable provision for their care and supervision. It is necessary to differentiate between day care for children of working mothers—that is, care and supervision throughout the working day—and the various forms of desirable provision for children who, because of crowded living conditions or for other reasons, need wholesome activities away from the home during part of the day to supplement the facilities of the home.

Two interests must be given due consideration in planning community day-care facilities: Production necessary for the national war effort and the needs of individual families and children. It is not a question of priority of the one or the other of these interests. The needs of essential industries must be served; children must not be deprived of home care needlessly, and they must be safeguarded if the mother is away from home. These objectives can be attained only if community action is based upon thorough knowledge of the various factors involved in employment of mothers of young children.

The community program for day care of children of working mothers will not help in meeting the needs of war industry unless it makes available the work of women who are actually needed for war production or other essential work. It will not benefit children unless safeguards are provided against needless shifting of responsibility for their health and welfare.

EMPLOYMENT OF MOTHERS OF YOUNG CHILDREN

The logical first-step in ascertaining the need for day care of children of working mothers in a given community is to obtain information in regard to the present situation and the plans for the immediate future with regard to employment of women. Employment of women in defense industries or other occupations is not in itself a gauge of the extent to which mothers of young children will be so employed, but it is inevitable that a demand for women workers will lead to employment of a considerable number of women who are mothers of young children. The relative proportion of these women will depend upon many factors, such as employment policies of individual plants and the labor supply available to the industry. It is necessary, therefore, to study the industrial needs in the area, the available labor supply, and employment policies bearing on the problem.

¹ See A Community Program of Day Care for Children of Mothers Employed in Defense Areas. Reprint from *The Child*, January 1942, pp. 152-161. Children's Bureau, Washington, 1942.

When the labor supply is limited so that it is necessary to recruit women to do work ordinarily done by men or when certain types of work can be done by women with equal or greater skill, it is probable that married women with families will be drawn into industry. In areas where housing of workers presents special difficulty all labor available in the community, and sometimes within a large radius, must be utilized. In such areas it is inevitable that workers will include a much larger number of married women with children than in communities where war industries have a less limited labor supply from which to draw workers. Each community, therefore, presents individual problems which must be understood if there is to be intelligent planning for day care of children of employed mothers.

Just as the industrial situation in defense areas is subject to many changes, so a community day-care program cannot be static. Even though war production industries in a given area may be working at full capacity, various contingencies may affect the situation so that it will be necessary to employ increasing numbers of women who have household responsibilities. In many areas it is known that large numbers of women will be employed when war industries reach full operation, and in some communities plants are now in process of conversion for war production. The extent to which women with young children will be employed can be estimated only in general terms, and the program for day care of children must be planned tentatively on the basis of probable needs. Even when it is impossible to obtain specific information until the plants are actually employing labor, counseling service might well begin to function and some day-care facilities should be planned so that when they are needed they may be established without undue delay.

Not only in war production industries but also in many allied occupations and in other manufacturing and business enterprises in defense communities will the employment of women be needed. Men are being drawn into war industries and their places in other manufacturing and business enterprises are being taken by women. Many of the places held by men who have entered the military service are being filled by women, and growing populations of defense areas create increasing needs. All these conditions should be included in the study of community requirements for adequate day care of children of working mothers.

Not all employment of mothers, however, necessitates full-time day care for children. When the day-care facilities are designed to

provide for children whose mothers work in war industries or in other occupations with long hours they must be equipped to give care and supervision throughout the working day. Certain other occupations in the community do not require the same range of hours and the needs of the children may be met under a modified schedule. A fact-finding study must take into account various types of situations, in order that care may be provided in accordance with actual needs.

Work shifts in defense industries present special difficulties, and an effort should be made to secure an arrangement whereby mothers who have responsibilities for the care of young children may be assigned to daytime shifts. If this cannot be done it may be possible for these mothers to obtain work in other occupations which will enable them to perform the double task of work away from the home and care of their children before and after their working day. Neither the child's health nor that of the mother could long stand the strain of the kind of program that has been proposed in some communities. Hours of employment and working conditions must, therefore, be studied in relation to plans for provision of day care.

Sources of information in regard to the need for day care in a community and the main items which should be covered in a study of employment of women in war industries are listed in the reprint *A Community Program of Day Care for Children of Mothers Employed in Defense Areas* (see footnote 1). The study should also include occupations other than those in war industries in such detail as may be desirable in view of the local situation.

NEEDS DISCOVERED THROUGH COUNSELING SERVICE

"Counseling service should be provided as a vital part of the case-work service which should be available to parents who need help in planning for the care of their children and those who need continued guidance and assistance in order that the welfare of their children may be assured."²

Situations coming to the attention of a central counseling service or of agencies giving such service will provide the most concrete information in regard to need for day care and the types of care required in the community. When several agencies in the community furnish advisory assistance to mothers who are

² See paragraph on counseling service in *A Community Program of Day Care for Children of Mothers Employed in Defense Areas*.

working or who are considering employment, their services should be coordinated so that there will not be diversity of policies. The central counseling service should receive from all such agencies reports on applications for care of children whose mothers are employed and the disposition of these requests.

STUDY OF EXISTING RESOURCES FOR DAY CARE

Employment of mothers of young children is already a very serious problem in many communities, where immediate action is necessary. In almost all cities there is some provision for day care. It is the part of wisdom to utilize existing resources to the fullest extent even though it may be necessary to make additional provision as rapidly as possible to supply urgent needs. The administrative experience of day nurseries and other facilities should be a valuable asset in planning adequate provision for day care.

Study of the standards of care in day nurseries and other day-care centers under whatever auspices conducted, of the types of service they are giving, and of the needs they are meeting is an important part of a fact-finding survey. If the standard of service makes it advisable to consider extension of present facilities, inquiry should be made into the practicability of extending these services.

The day-care program of a community should make provision not only for day-care-center or day-nursery type of care for preschool and school-age children, but also for care and supervision before and after school. It is, therefore, essential that study concerning needs and available resources should include neighborhood houses and settlements, recreation centers, and activities conducted by churches and other organizations which may be utilized in providing for children of school age. This should, of course, include inquiry concerning provision made by public and parochial schools for care and supervision of school children during hours when their mothers are away from home.

In many cities, in preliminary exploration of the day-care problem, special committees of councils of social agencies or local defense councils, in order to obtain information concerning the situation in the community, have been receiving reports from day nurseries, nursery schools, family-welfare and child-welfare agencies, neighborhood houses, and other organizations in regard to applications for day care and requests for information or assistance. The fact-finding group should take immediate steps to obtain such information on a uniform plan which will provide adequate data and will show whether the individual sit-

uations appear to require day care for children whose mothers are employed or seeking employment or whether other forms of case-work service are indicated.

Suggestions in regard to study of day-care services given by various community agencies and the needs discovered by them are included in the reprint already referred to in a section entitled "Study of Existing Resources for Day Care."

SOURCES OF INFORMATION CONCERNING SPECIFIC DAY-CARE NEEDS

It has been suggested that the first step in a study of the community's need for day-care facilities is to determine the present and prospective extent of employment of women in defense industries and in other occupations essential to the war effort, and insofar as possible to ascertain the extent to which women who have young children will be needed for this work. It is also necessary to obtain information on policies relating to employment of women in war industries.³ General plans for a community day-care program can be developed on the basis of facts so obtained, and in some communities, especially in areas where war industries are established in small, rapidly growing centers where no resources exist for the care of children, it will be necessary to undertake at once to establish some projects for certain types of facilities.

Knowledge of the approximate extent of employment of women with young children is only a small part of the problem. In order to establish day-care centers and other services for the care and supervision of children of employed mothers it is necessary also to know where these facilities should be located in order to be available to those who need them. The workers in many war industries come from large areas and from surrounding towns and cities. In order to be within reach of the mothers before and after their work, day-care centers should be located so that an undue amount of time, energy, and travel cost is not involved.

Before-and-after-school facilities for school children of necessity must be located in or near the schools which the children attend. Resources for care and supervision of school-age children should be either near the home or in the vicinity where children of preschool age are cared for so that a mother may not have too great difficulty in leaving children of preschool and school age in the morning and tak-

³ See statement distributed by the Children's Bureau entitled "Policies Regarding the Employment of Mothers of Young Children in Occupations Essential to the National Defense."

ing them home when her work is over. These problems involve not only questions of location of day-care facilities but also the practicability of utilizing various types of care. For example, in some cases foster-family day care or service in the home during the mother's absence may be indicated as the desirable method, rather than the use of a day-care center or day nursery. It will sometimes prove impracticable to arrange for the mother's employment because the health and welfare of her children could not be assured through any day-care resources which could be made available.

Fact finding must also be concerned with situations which arise when families do not recognize the need for safeguarding their children during the mother's absence from the home. Even when they are informed about day-care facilities some families, for one reason or another, do not avail themselves of such care, and the safety and health of their children may be endangered or the children may become wayward because they are left to their own devices. These conditions must be discovered, and the parents must be helped to make arrangements for the proper care and supervision of their children.

The problems which have been mentioned make it essential that a survey of the employment situation and other general factors shall be supplemented by inquiries which will obtain specific information needed as a basis for expanding existing facilities and creating new ones. Communities now actively concerned with the problem of care and supervision of children whose mothers are away from home because of employment have utilized various methods of obtaining information. Most of them have had in mind the needs of school-age children as well as of preschool children. Some of them have obtained information which gives a general idea of the extent of the problem but which lacks specific facts needed in order to plan the location of day-care centers and the types of other services that may be required. Many of these facts will not come to light until some day-care facilities actually become available and families have had an opportunity to make the arrangements which seem to them to be desirable, but as much specific information as practicable should be obtained in any fact-finding study.

The inquiry to ascertain the need for day-care facilities should differentiate carefully between need for full-time care and supervision of children whose mothers are employed in occupations with long hours of work and need for activities during part of a day or intermittently. It is uneconomical, both in expenditure and in personnel, to utilize day-care

facilities for children whose needs may be provided for adequately by nursery schools, play centers, child-development centers, and similar activities. Provision is urgently needed for such part-time care, especially in communities in which families live in trailer camps or under other conditions that make it desirable to provide care and training for the children away from the home. When the mother's hours of work are short or when there is a responsible adult in the home who can look after the children most of the day, the care required by children of employed mothers may be supplied in this way. But in general this type of provision does not meet fully the needs of children of working mothers, and facilities that supplement the home should not be confused with provision of day care, which is a substitute for the child's home during the mother's working day.

Mention has been made of the importance of information from counseling service and from existing day-care resources as sources of data. Among other methods which have been used in securing information regarding needs that must be met through various types of day care are:

(1) Surveys of limited areas of a city in which employment of mothers appears to be prevalent, through obtaining general information and as much specific data as possible from welfare agencies, health agencies, labor organizations, churches, schools, and various groups located in the area or knowing conditions there.

(2) Inquiry covering a housing unit or units, to get information about children of employed mothers and provision made for their care.

(3) Inquiries among women employed in war industries. Information should, if possible, be obtained from the women themselves by some method which does not involve the employers. This might be done through training classes for war workers, labor unions, or other organizations. Information might also be obtained through questionnaires to be distributed directly to women employed in certain industries by representatives of the fact-finding group and returned to them sealed. It is necessary to avoid any implications that the information given will affect employment.

(4) Questionnaires distributed through schools, to be taken home by the pupils and filled in by the parents.

All questionnaires or other forms on which information is recorded as a basis for plans to meet actual needs for day care should include at least the following items:

Name and address of the family.

Is the father employed?

If the mother is now employed, where does she work?

What are her hours of work?

If the mother is not now working, but intends to secure employment, where does she expect to work?

Ages of all children in the household.

For children attending school, name of school; for children employed, place of employment and hours of work.

Older children and relatives or other adults in the household who are not working and who may look after the young children during all or part of the day.

If the mother is now employed, are her children of preschool age cared for in a day nursery, a nursery school, or some other center?

Are they cared for by relatives or neighbors?

Are they cared for in some other family home through arrangements made by the mother? By a child-welfare agency?

Are they looked after in the home by an older child (sex and age), or by a relative or other adult? By neighbors?

Does the mother want advice or assistance in securing day care or in finding more suitable care for her children?

If the mother is contemplating employment, how will her children be looked after during her absence? Does she want help in obtaining suitable care? What type of care would she like for her children?

Questions in regard to family income and the amount which the family could pay toward the maintenance of the children in a day-care center, in a foster-family home, or through other type of provision can well be omitted from this inquiry. These are matters which should be gone into when the children are received for care—in accordance with policies which have been determined by the agency providing care. Provision of day care and quality of service should not depend upon the parents' ability to pay; the only consideration should be the kind of care needed by the children. It may be desirable, however, to obtain some facts in regard to the family's economic status, race, religion, mode of living, and other conditions which need to be known in order that the child may be placed in a group or in a foster family in which he will feel "at home."

THE BACKGROUND OF FACT FINDING

Planning for study of day-care needs in a community and interpreting the findings require a broad understanding of the objectives of day care and the principles which are essential to maintenance of the health and welfare of mothers and children. If the community program for day care is not founded upon policies which will promote the well-being of the individuals concerned and which will conserve the interests of the community, facilities provided for day care may create more problems than they solve.

Day-care centers or other facilities do not of themselves solve the problems of working mothers; sometimes they may even complicate situations. Those giving counseling service must be equipped to differentiate between situations which indicate need for day care and situations which should be dealt with in a very different way. It is equally necessary that

those engaged in fact finding shall be able to distinguish between situations which indicate need for day-care service and those which may require other kinds of help.

An illustration of the difficulty involved in fact-finding studies has recently come from England where, in a house-to-house canvass, a large number of women answered "yes" to the question whether they would take defense industry jobs if provision were made for care of their children; nevertheless, when the facilities became available many of these mothers had made other arrangements for the care of their children. Another suggestion which has come from England within the past month or two is that unless there are unusual circumstances it is not advantageous for a mother of more than one or two children to be employed if her children must be cared for in a day-care center, since the work of the mother will not compensate for the personnel required to look after her children.

A point of view resulting from English experience is stated in the following excerpt from *Mother and Child* (London), March 1942:

What is a day's work? * * * *Mother and Child* is particularly interested in the problem as it affects women with children. What is a full day's work for them? * * * A married woman with children for whom the Government has provided the luxury of a day nursery * * * has to get to work by 7 o'clock, but, before she goes, she has to get the children up, prepare the younger ones to go to the nursery and the older ones for school; make the breakfast for the family, take the "under 5s" to the nursery, and then go to work. If she is lucky she may get home at 5 o'clock. If she is doing overtime she may not get home until 7 o'clock. On her way home she has to fetch the "under 5s" from the nursery, prepare tea for them, get supper for her husband, and do all the household work. It immediately becomes plain that the married woman with children has at least 4 or 5 hours' work to do, apart from her work in the factory.

What is the answer to all this? It is that in making arrangements for placing married women with children in factories account must be taken of a woman's household duties. She should not start her work in the factory until 9 o'clock, and she should be home by 4:30. Nor is this suggestion so uneconomic. It will save all the expense of the labor associated with maintaining nurseries from 7 o'clock to 9 o'clock in the morning and from 5 o'clock until 7 o'clock in the evening. * * *

Important as all this may be, it plays a secondary part to considerations of health. It cannot be, and it is not, right for a young child to be taken out of bed at 6:30 in the morning, hastily clothed and fed and possibly washed, and hastened in all weather to a day nursery. Nor can it be right so to separate mothers and their children that they meet only at week ends. War is war and there are a lot of things one has to do which would appall one in peacetime. If such actions be necessary and calculated to win the war, then we must still our voices. But if they be uneconomic, then the sooner they are considered in the light of fact the better.

Washington Trains Volunteers for Day Care of Children

BY ALICE COE MENDHAM

Chairman, Emergency Committee for Day Care of Young Children, Washington, D. C.

Thirty-five students have now completed the lectures constituting the first part of the first training course for volunteers in child care to be given in the District of Columbia, and are doing practice work under guidance.

The training course for volunteers was initiated in Washington by the Council of Social Agencies. It was organized and carried out through the cooperation of several interested groups in the community: The Emergency Committee for the Day Care of Young Children;¹ the Civilian Defense Volunteer Bureau; the American Women's Voluntary Services; the Women's Auxiliary of the Congress of Industrial Organizations; and the Association for Childhood Education.

First Steps.

As a first step in organization a meeting of interested groups was called to make a general plan. This was attended by representatives of the health department, the local child-guidance clinics, and child-welfare agencies, and by medical-social workers and preschool specialists. It was decided to address the course toward training nursery-school aides, since an important need in Washington is for additional facilities for day care of preschool children and for expansion of existing facilities with the use of volunteer personnel. From the large organizing group was appointed a curriculum committee, a committee to interview volunteer candidates, and a publicity representative. This smaller group of committees became a steering committee which managed and planned the working arrangements for the course.

Before a large representative group is called together it is essential to have tentative plans clearly outlined for discussion; and to have well in mind the particular needs of the community involved. Placement of students in nursery schools for practice work also presupposes a thorough survey of existing facilities for nursery care, such as had been made by the Emergency Committee for Day Care of Young Children in the metropolitan area of Washington.

Selection of Volunteer Students.

The training course was limited to 50 students between the ages of 21 and 50 years

(those accepted in the upper age group would have to be vigorous in body and flexible in mind) with at least high-school education. Appointments for personal interviews with applicants were arranged by the committee through the Civilian Defense Volunteer Bureau, the American Women's Voluntary Services, and the Women's Auxiliary of the Congress of Industrial Organizations.

The interviewers on the committee were professionally trained social workers who gave time for this purpose. A trained nursery-school specialist helped with each interview, so that questions on the work involved could be answered directly. Candidates who were obviously unfitted for work with children were discouraged from taking the course and urged to go into other kinds of volunteer work. Women who were found to have any emotional or nervous instability, any fixed ideas on child management not in harmony with modern procedures, or any serious physical defects were considered ineligible.

Volunteers were asked to give 3 half days of work per week in a day-care center after the period of training. This time requirement was a factor in eliminating some of the applicants.

Time and care spent in interviewing candidates at the beginning save much time and effort in the end for both volunteers and those giving the course. Fifty-seven students were enrolled, with the expectation that some would drop out. Thirteen students did drop out: 4 because of illness, 4 because they moved out of town, and 5 for financial reasons, such as getting a paid job, or finding car-fare expenditures beyond their budget.

Curriculum Planning.

The curriculum committee, consisting of professional nursery-school teachers and social workers, planned 10 lecture-discussions, covering briefly the main points of emphasis in nursery-school training (see outline, p. 287).

For each lecture a specialist in the field was chosen to talk for 45 minutes, after which there was a panel discussion with questions from the students. The panel was designed to include a nursery-school teacher, a social worker, a pediatrician, and an additional specialist in the particular field under discussion. The chairman of the committee, a nursery-school specialist, was appointed to coordinate the course generally as well as to give the lectures on nursery-school techniques.

¹The Emergency Committee grew out of the Advisory Council on Preschool Education, which was reorganized to conduct a survey of preschool facilities and to maintain an information center on day care of young children.

Field Trips.

A series of field trips for observation was planned in connection with the lectures. The most feasible way of handling these trips was to divide the students into groups of 10 or fewer and to make appointments for each group with the school or clinic to be observed. Former nursery-school teachers accompanied the students on trips to point up discussion and observation.

Contacts with child-welfare clinics and nursery schools were made well in advance to assure full cooperation of the staff and adequate room for the observers. The places chosen for field trips were picked carefully for the learning opportunities they presented. Where possible the observations were scheduled to follow immediately the lecture on the subject, e. g., a visit to a nursery school at the meal hour was made after the lecture on nutrition.

The lecture-discussions were given 2 mornings a week, and the field trips were made on a third morning. Thus the lecture and observation part of the course took 5 weeks.

Field trips and observations

1. Nursery school—function of teacher in play situation.
2. Clinic at Children's Hospital—children from babyhood to 6 years, where guidance in both psychological and physical care is given to mothers.
3. Meal hour at the nursery school.
4. Routine of child's day in the nursery school.
5. Staffing of case at Child Guidance Clinic.

In the middle of the course a written paper was assigned to the students on the basis of subjects discussed, suggested readings, and observations. After going over the papers, the training staff met to evaluate the techniques and procedures used in training adults in a field new to them. It was decided to discontinue the panel discussions after the lectures and to substitute discussion groups of 10 to 15 students, each with a discussion leader. Par-

ticipation of students in discussion is particularly important in adult education if there is to be a real learning process.

Practice Training.

A personal interview with members of the executive committee was arranged for each student to determine whether or not she should be admitted for a 50-hour practice period of training in actual nursery-school situations. As a result of this second interview a few more students were eliminated for various reasons. Thirty-five students were placed in private and settlement-house nursery schools for practice work under guidance.

Under arrangements with the nursery schools that had been selected and asked for cooperation, a preliminary period of observation for the students with explanation of routine and procedures precedes any actual work with children. Each student is given rotating assignments with each age group in sequence and helps the children at the toilet, in washing, at meals, and with each part of the program so that she will have experience with the full day program. The students have a weekly conference during the practice period with the head of the school and a representative from the training-course staff to discuss problems arising in the work.

It is important to consider the convenience of the volunteer students in making practice-teaching assignments, as to both location of the school and hours that fit into individual schedules. This is a lengthy process but well worth the effort in preserving the student's feeling of enthusiasm for the work.

Handbook.

For the students' permanent use a handbook is being prepared containing a digest of the lectures given as well as other comprehensive material on child care. Some of the Children's Bureau pamphlets are included.

OUTLINE OF LECTURE-DISCUSSIONS

1. Orientation, by nursery-school specialist.
Why nursery school?
Observation techniques.
Relation to general child-welfare program.
2. Physical growth and development of the young child, by a pediatrician from the health department.
3. Nutrition: planning low-cost menus for the young child, by a nutritionist.
4. Mental growth and development of the young child, by a psychologist from the Children's Hospital.
5. General principles in management of children, by a nursery-school specialist.
6. Habit formation, by a nursery-school specialist.
7. Social and emotional development of the young child, by a psychiatrist from the Child-Guidance Clinic.
Nursery-school routine adapted to growth of child.
How a nursery school plans its program to meet physical, mental, social, and emotional needs.
8. Importance of play in the young child's day, by a nursery-school specialist.
9. Special emergency situations, by a nursery-school specialist.
10. Community responsibility and services, by a social worker.

Placement of Trained Volunteers.

Actual placement of students as volunteer workers in day-care centers is made by a committee consisting of a representative from the Civilian Defense Volunteer Bureau, the American Women's Voluntary Services, and the training-course staff which includes a representative of the Council of Social Agencies. Requests have already come in from the settlement-house nursery schools and other community groups for trained volunteers. The students will be placed according to the needs of the individual centers, with consideration

for the volunteer's own preference and convenience.

In general a training course for volunteers requires a good deal of thoughtful planning and careful arrangement if it is to run smoothly. Members of the committee doing the planning must be prepared to give almost full time to the work during the lecture period and for 2 or 3 weeks before and after the course.

The training course has been given without any expense to the community, through utilization of the volunteer services of professionally trained people.

Special Certificates of Birth Registration for Adopted Children

BY AGNES K. HANNA

Director, Social Service Division, U. S. Children's Bureau

At the present time many persons who have adopted a child are unable to obtain a certificate of birth registration including data from the child's original birth certificate such as sex and date and place of birth, yet showing his legal name and family relationship acquired by adoption. This difficulty may be due to lack of a law authorizing the registrar of vital statistics to prepare such certificates or to limitations imposed by the statutes. A recently reported case illustrates this latter situation. A child was adopted in a State whose law authorized the preparation of a certificate only for a child *born* in the State, yet the State in which the child was born authorized preparation of a certificate only for a child *adopted* in the State.

It is not a minor matter that this child and many another child must use for school admission and work permits as well as for other purposes later, a certificate of birth showing a name that is not his legal name. If there is any meaning in the basic principle embodied in adoption laws that a child on adoption has the status of the adoptive parents' own child, such status should be fully protected in birth-registration laws. This cannot be done until provision is made in every State for preparation of a special certificate for any child born in the State who is adopted, regardless of the State in which the adoption occurs. At present less than half of the States have such provisions.

The laws of 34 States and the District of Columbia give fairly clear indication of the children that come within the provisions of the law. The law of 1 State does not define the children included, and in 3 other States and Alaska the adoption law provides for issuance by the State registrar of a copy of the

adoption decree, or for report of the adoption to the State registrar. Ten States have no statutory provisions on this subject. Reports from some States indicate that certificates of registration bearing the new name of the child are issued for some adopted children under an administrative ruling.

The following outline of provisions found in these 34 States represents merely an interpretation of statutory provisions that in many States are supplemented by rules and regulations or administrative decisions. Furthermore, the provisions of some of these laws are by no means clearly defined, hence are open to differences in interpretation. The major value of this analysis of the coverage of these provisions in the several States is to call attention to the inadequacy of many of them and to the need for careful consideration, when legislation is being drafted, of the extent to which adopted children can benefit from the proposed plan.

1. Preparation of certificates limited to children adopted in the State.

The laws of 16 States relate only to children adopted in the State. In 7 States the provision is found in the adoption law; hence it relates only to the children for whom decrees of adoption are granted by the courts within the State. The present provisions of the District of Columbia also are in the adoption law. In the remaining 9 States in this group the provision is found in the vital-statistics law, but its application is limited, either specifically or by reference to the adoption law, to children adopted by the courts of the State.

An adopted child may have been born in the same State in which he is adopted or he may have been born elsewhere. Limitation of

preparation of special certificates to children born and adopted in the State means that a child adopted by residents of the State but born elsewhere cannot obtain a special certificate unless he is fortunate enough to have been born in a State that provides such a certificate for any adopted child born in the State. Even when the law might be interpreted as applying to a child adopted in the State but born elsewhere, no provision is made in this group of laws for a child whose birth record may be on file in the State but who was adopted in another State.

a. The provisions of the following States of this group apparently or specifically limit the preparation of new birth certificates to children born in the State:

Alabama	Idaho	South Dakota
Delaware	Indiana	Washington
Georgia	Kentucky	Wisconsin

b. The provisions of the remaining States are broad enough to indicate the possibility of preparing a certificate for a child adopted in the State but born in a State having no provision for change in the birth record on adoption in another State. Reports from two of these States show that such certificates may be prepared on request of the adoptive parent and submission of a certified copy of the birth certificate of the child.

Illinois		Nebraska
Maine	Mississippi	Ohio
Michigan		Texas

2. Preparation of certificates for children adopted in the State or elsewhere.

Where provisions authorizing the preparation of a certificate for a child adopted in the State or elsewhere exist, they are found in vital-statistics laws. In two States the vital-statistics law provides for certificates for children adopted in other States and supplements the provision in the adoption law for children adopted in the State.

In this group of 18 States the laws provide protection for any child born in the State who has been adopted, whether the adoption was granted by a court of that State or of any other State. The place where the adoption occurs has little significance as compared with the value of having the special certificate pre-

pared by the bureau or division of vital statistics of the State in which the child was born and the original birth record was filed.

a. The provisions of the following States of this group apparently or specifically limit the preparation of certificates to children born in the State:

California	Nevada	Pennsylvania
Connecticut	New Jersey	Tennessee
Florida	North Carolina	Vermont
Louisiana	North Dakota	West Virginia
Minnesota	Oregon	Wyoming

b. The provisions of three States (Maryland, New York, Oklahoma) are broad enough to indicate the possibility of preparing a certificate not only for any child born in the State, but also for a child adopted in the State but born in a State having no provision for change in birth record on adoption in another State. The New York law is the only one that specifically authorizes the preparation of a certificate under these circumstances.

Since adoption laws apply only to children dealt with by courts having jurisdiction in adoption proceedings, provisions in these laws should be superseded by enactment of broader provisions in the vital-statistics law. It is desirable, however, to require in the adoption law that the court send to the bureau or division of vital statistics a report of each adoption with such supplementary information as may be needed for preparation of a certificate. If the child was born in another State, the record can be transmitted by the registrar to the State in which the birth occurred.

It is evident that there is need for broadening and clarifying many State laws on this subject and for enactment of provisions in States having no law. Limitation of the preparation of special certificates to children adopted in the State is a serious matter to a child born in the State but adopted elsewhere. As long as such limitations exist, any State that is concerned with the welfare of a child adopted in the State by residents of the State may be faced with the need for preparing a special certificate based on a birth record of another State. Such a plan should be looked upon, however, as a temporary measure pending the enactment of more adequate provisions in all the States.

BOOK NOTES

STATE SUPERVISORY PROGRAMS FOR THE EDUCATION OF EXCEPTIONAL CHILDREN, by Elise H. Martens. Bulletin 1940, No. 6. Washington, 1941. 92 pp. The organization and supervisory functions and activities of State programs for the education of exceptional children are described in this monograph. Sixteen States are stated to have programs of this nature.

STATE-WIDE TRENDS IN SCHOOL HYGIENE AND PHYSICAL EDUCATION, by James Frederick Rogers, M. D. Pamphlet No. 5 (revised). Washington, 1941. 15 pp.

Looking back over a half century of health work in schools, Dr. Rogers finds unquestioned acceptance of physiology and hygiene as a part of the curriculum, at least in elementary schools; widespread acceptance of physical education with a gradual transition from the gymnastic period to instruction in games and rhythmic activities; and a great variety of legislation providing for medical inspection. Tabular summaries are given of State legislation on physical and health education and on State legislation for medical inspection.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

Public-Health Services in the Clark County Defense Area¹

BY ROBERT E. JEWETT, M.D.

Assistant Chief, Bureau of Maternal and Child Health, Indiana State Board of Health

The establishment of large-scale defense programs in semirural and rural counties is attended by serious public-health problems, due to the influx of a large number of workers and their families. A sudden increase in population in an area leads to overcrowding; it overtaxes sanitary, nursing, medical, and hospital facilities, and it increases the seriousness of all community public-health problems. When the United States Army Ordnance Plant was established in Clark County, the army of workers employed in construction and operation of the plant greatly increased the population of the county, and the problems created by a sudden population increase had to be faced. It is not possible in a short article to report fully on progress made in solving all the problems, but the problems may be pointed out, and the progress made in increasing public-health nursing and maternity-nursing services will be discussed.

Before large-scale defense programs were begun in 1940, Clark County had an estimated population of 31,000 (see table), with 13,000

in the county, and there were 3 public-health nurses.

By the beginning of the summer in 1941 the population of Clark County had increased to 40,000, and there was every evidence of overcrowding. Water and sewage facilities were overtaxed, schools were inadequate, and the hospital in Jeffersonville was crowded beyond its capacity. Many trailer camps sprang up, one-family houses were accommodating several families, restaurant facilities were overtaxed, and office and store space was exhausted. The town of Charlestown, closest to the ordnance plant, was the most pressed, and began to take on the semblance of a "boom town."

The need for increased facilities and services was quickly realized by local, State, and Federal officials, and plans have been made to alleviate the situation. Every affected group and agency has assumed its share of responsibility, and at the present time big strides have been made. * * *

Under the direction of the bureau of sanitary engineering of the State board of health and the district health department, efforts were made to provide safe and adequate water supplies, to insure the safe and satisfactory disposal of sewage and garbage, to provide for supervision and regulation of housing and trailer camps and eating establishments, to foster local ordinances designed to insure safe milk supplies, and to plan programs for mosquito abatement.

Most pressing of the public-health needs in Clark County was the need for extension of public-health-nursing services. At the outset there were only three public-health nurses in the county, a nurse employed by the Clark County Tuberculosis Association, an American Red Cross nurse in Jeffersonville, and a general public-health nurse employed by the county in cooperation with the State board of health. Two additional public-health nurses were placed in the county by the State board of health early in 1941, and two public-health

Population, births, physicians, and public-health nurses, Clark County, 1940 and 1941

	1940	1941
Population (estimated)-----	31,000	40,000
Births-----	533	607
Hospital deliveries-----	108	228
Home deliveries-----	425	379
Public-health nurses-----	3	5
Physicians-----	23	23

¹ Nurse employed in the city of Jeffersonville, and one nurse employed by the county tuberculosis association.

persons residing in Jeffersonville, the county seat, and the remainder scattered in the county and the several smaller towns. There were 533 births in the county, 425 occurring in the home and only 108 in a hospital. There were 15 physicians practicing in the city of Jeffersonville, and 8 physicians located in smaller towns

¹ Except for a few paragraphs added by the author, this article appeared originally in *Monthly Bulletin* (Indiana State Board of Health) Vol. 44, No. 2 (February, 1942), pp. 27, 39-40.

nurses especially trained in maternity and infant care were placed there in December 1911.

The public-health nurses of the county, under the supervision of the district health department, and nurse consultants of the State board of health have conducted many group teaching programs for mothers. Other educational programs, covering all phases of public health, have been carried out in the county by personnel of the bureau of health and physical education of the Indiana State Board of Health.

A series of lectures on nutrition and family budgeting was given during January and February 1942 by the nutritionist of the bureau of maternal and child health. This lecture service was designed to reach mothers' groups, teachers, and related groups. Interest and response gradually increased as the groups began to grasp the subject.

A permanent child-health conference has been established in Jefferson by a local sorority in cooperation with county public-health nurses and the bureau of maternal and child health of the State board of health. The community is providing quarters, and necessary equipment and fees for a physician and a dentist will be provided by the bureau of maternal and child health. A qualified pediatrician and a dentist will give their services in conducting the conference. This type of service will be extended to other parts of the county as soon as quarters are available.

Extensive immunization programs have been carried out in Jeffersonville, and programs for the remainder of the county are being stimulated. Fees for physicians conducting immunization programs will be provided by the bureau of maternal and child health. * * *

The Clark County Hospital, situated in Jeffersonville, has been wholly inadequate. Plans have been approved by the State board of health for the building of a 60-bed addition at an approximate cost of \$190,000, with quarters and facilities for prenatal clinics, venereal-disease clinics, or other clinics.

With the great influx of new families into Clark County it was immediately evident that school facilities were inadequate, particularly in Charlestown. By the use of local resources and Federal grants, a large and modern school is being built in Charlestown at an approximate cost of \$600,000 and should be ready for occupancy by September 1942. Plans have been made by the district health department, in cooperation with local authorities, to provide quarters for public-health offices and clinic facilities in the new school building.

A series of educational programs in maternity care was conducted during the latter part

of 1940 and 1941 by the State board of health and the district health department and a series of programs on care of the infant, preschool child, and school child was given by the State board of health in 1941. These programs, which are being continued in 1942, are designed to improve the knowledge of public-health services for mothers and children among the public-health nurses and welfare workers.

One of the most interesting and useful public-health services established in Clark County is the maternity nursing service. The purpose of this service is to provide assistance to the community and to the physician in the battle to reduce the hazards of motherhood and infancy. From 60 to 80 percent of infants born in Clark County are delivered in the home, and with the overcrowding and unsatisfactory conditions frequently encountered it can be a difficult process.

The chief function of the service is to provide the physician in attendance at a delivery with a trained nursing assistant. Other duties of the maternity nurse consist of educating prospective mothers in the hygiene of pregnancy, assisting in preparations for home delivery, carrying out the orders of the attending physician, and supervising the care of the newborn infant. * * *

The maternity nursing service is available to the patients of all physicians who give their approval. From the time of its establishment [December 1, 1941] the service has met with favor, many prospective mothers were soon being called upon, and assistance was provided for three deliveries before the end of December. The service has continued to expand, and eight deliveries were attended during the last week of January. The benefits of this service to the mother, to the physician, and to the community should be great.

Much has been done in Clark County to meet the social and health problems, and much still remains to be done. Housing conditions are improving, and trailer camps are shrinking in size. A program for expansion of the schools and the county hospital is under way, but construction will not be completed for some time. The program to improve sanitary facilities is under way, and it has made great progress. It is felt the greatest progress has been made in increasing public-health-nursing services and in establishing the maternity nursing service. All programs may need to be expanded still more if the press of war increases. Programs for the control of communicable diseases and the protection of public health should be extended now, of all times, for never was it more important to keep our citizens healthy.

Health Services in Hawaii

With women and children crowded into evacuation centers hastily established in public buildings; with schools closed; with communication by radio suspended and a complete black-out of all lights at night; with shipment of food stuffs and other supplies disrupted; and with personnel depleted by the entrance of the Director of the Bureau of Maternal and Child Health on duty with the Army and of the Director of Public Health Education, with the Navy, the Board of Health of the Territory of Hawaii was able to report in December 1941:

Within an hour after the first bombs fell, the executive heads of the health department were in conference and plans and arrangements were made for carrying out the various services which seemed to be required at the moment. * * *

After the attack, requests by hospitals and physicians in charge of first-aid units were made for various essential biologies. Prophylactic tetanus antitoxin was in particular demand. * * * An immunization station for inoculation against typhoid fever and vaccination against smallpox was opened in the office of the board of health. Restaurant and general sanitary inspection services were intensified. Food supplies were carefully checked. Dairy inspection service was augmented and every assistance given to insure a continued supply of clean and wholesome milk and dairy products. * * *

In view of the close proximity of residential districts to many military objectives, it became immediately necessary to evacuate large numbers of civilians and military dependents to sections of the island removed from the points of attack. One of the important services rendered by the nursing department was the health supervision at evacuation centers where large numbers were being housed in schools, churches, and other community buildings. A number of nurses reported to first-aid stations and hospitals for emergency nursing services. Other nurses, particularly in rural districts, supervised the setting up of first-aid stations and obtaining necessary supplies for their operation.

In order to make available additional beds in local hospitals for war casualties, it was necessary to evacuate certain patients for home care. Public-health nurses were placed on call for bedside-nursing care of these and other patients upon the request of a physician. Private physicians were notified that this service was available and were urged to utilize public-health nurses when private nurses were not obtainable.

Maternal and Child-Health Conferences.

Notices were sent out to all physicians responsible for maternal and child-health conferences instructing them that "maternal and child-health conferences are to be continued as scheduled unless a dire necessity makes it inadvisable," and that "regular child-health conferences, including immunization against smallpox and diphtheria are to be continued."

On January 9, 1942, a member of the Board of Health of Hawaii wrote:

On December 8 and 9 conferences, both maternal and child health, were poorly attended as one might well expect. Difficulties also arose over physicians

keeping their appointments, as many had been called and had put in long hours, while others were still needed at the military hospitals. However, by the end of the week, conferences in Honolulu were running as scheduled with almost full attendance. It seems to me that this is a splendid example of the population's ability to adjust to even a major shock. Rural Oahu did not have conferences running until a little later, as the limited personnel made substitution difficult.

Obstetric Service.

The same letter reports that relatively few women have been delivered in their homes since the disaster. Only 4 of the 36 licensed midwives in Honolulu are citizens of the United States and, as only citizens are allowed to travel at night under the black-out regulations, the other midwives must either go to the patient's home by daylight and remain until the next day or turn their night cases over to hospitals.

Women are urged to come to the hospitals for delivery and to come during daylight hours if they think labor is beginning, as driving a car or ambulance with dimmed lights through the blacked-out streets is hazardous.

Emergency packs for use in home deliveries have been prepared and are at hand in all rural offices of the board of health. They are available also for the use of private physicians.

Premature Infants.

The home nursing service for premature infants, which was running smoothly before December 7, has been maintained. A physician and a public-health nurse carrying a portable bed and essential clothing for the infant, gowns, masks, and oxygen, reach the home within an hour after the call is received.

Nutrition.

Instructions for using island foods for feeding infants in the absence of imported supplies have been prepared by the nutritionist of the bureau of maternal and child health and have been published in local newspapers.

The "substitutes" suggested for orange juice and for some commercial infant foods have the unusual advantage of being superior to the standard article in many respects. Strained papaya diluted with an equal quantity of boiled water is as rich in ascorbic acid as is undiluted orange juice; home-made guava juice is 10 times as rich; and "pineapple juice will certainly always be available in Hawaii." Native raw sugar contains as much iron as a common brand of corn sirup and 5 times as much calcium.

NOTE.—Compiled from *Hawaii Health Messenger* (Board of Health, Territory of Hawaii), December 1941; from mimeographed material issued by the Board of Health; and from Children's Bureau correspondence.

• CHILD LABOR •

• YOUTH EMPLOYMENT •

• VOCATIONAL OPPORTUNITIES •

General Advisory Committee on Protection of Young Workers

Protection of young workers in wartime was the first subject considered by the Children's Bureau General Advisory Committee on Protection of Young Workers. Appointed in January 1942 for a 2-year term, the 25 members and 5 Government advisers of the committee met for the first time on February 26 and adopted the following statement:

STATEMENT OF PRINCIPLES ON USE AND PROTECTION OF YOUNG WORKERS IN WARTIME

The education and healthful growth and development of children and young people are of fundamental importance to our war effort. They are equally essential in preparing young people to take the vital part which must be theirs in carrying forward during the difficult post-war period.

It is essential that children and youth be sound and well-prepared in body and mind for the immediate urgent tasks which we face today and tomorrow, and that they shall be more, rather than less, well-grounded in the fundamental concepts of democracy for which we are fighting, with a breadth of vision and ability to think clearly on all the issues before us.

For children under 14 years of age, participation in life, school, and leisure-time activities and play should be regarded as the full-time program.

For children between 14 and 16 years of age the best development of their powers should be the major consideration in relation both to school and to productive employment. For them, education, health, and play are of major importance. Any work in which they are engaged should be such as to contribute to their health and educational development.

For boys and girls between 16 and 18 years of age, the question of continuance in school or entrance to employment should be determined by intelligent planning, rather than on the basis of hasty and ill-judged decisions. Youth between 16 and 18 years of age should be encouraged to remain in school, particularly those whose aptitudes and interests are such that they will gain most by continuing in school. For young people of this age such employment as they are called upon to perform should, as far as possible, lead to an improvement in their skills and educational preparation for life, or at least be accompanied by supplemental education which will achieve that object. Employment for this group, should be safeguarded from too long hours of work, from too great strain, and from work in occupations which are particularly hazardous or detrimental to health or well-being.

Nothing is more important for children and youth of all ages than a program which will aid them to think clearly and independently and to develop initiative and sound judgment in dealing with problems of both the present and the future.

This expression of principles is made for the purpose of providing a guide to wise and well-considered action

as we face problems arising from the critical nature of our national wartime needs.

The members of the committee are:

Chairman, Charlotte Carr, Hull House, Chicago, Ill.
David C. Adie, New York State Department of Social Welfare, Albany, N. Y.

Frederick H. Allen, M. D., Philadelphia Child Guidance Clinic, Philadelphia, Pa.

Mrs. Harris T. Baldwin, National League of Women Voters, Washington, D. C.

Lima E. Bresette, Social Action Department, National Catholic Welfare Conference, Washington, D. C.

John Brophy, Congress of Industrial Organizations, Washington, D. C.

Milt D. Campbell, American Legion, Indianapolis, Ind.
Henry P. Carstensen, Washington State Grange, Seattle, Wash.

Walter D. Cocking, Office of the Administrator, Federal Security Agency, Washington, D. C.

Donald Comer, Avondale Mills, Birmingham, Ala.

Courtenay Dinwiddie, National Child Labor Committee, New York, N. Y.

Mrs. Gladys Tallott Edwards, Farmers Educational and Cooperative Union of America, Jamestown, N. Dak.

Willard E. Givens, National Education Association, Washington, D. C.

Alonso G. Grace, State of Connecticut Department of Education, Hartford, Conn.

Charles S. Johnson, Fisk University, Nashville, Tenn.

Mrs. William Kleizer, National Congress of Parents and Teachers, Chicago, Ill.

S. Z. Levine, M. D., New York Hospital Children's Clinic, New York, N. Y.

Charles P. McCormick, McCormick & Co., Baltimore.

Ralph McGill, The Atlanta Constitution, Atlanta, Ga.

Josephine Roche, Rocky Mountain Fuel Co., Denver, Colo. Also National Consumers League, New York.

Mrs. Raymond Sayre, Iowa Farm Bureau Federation, Des Moines, Iowa.

Mrs. Charles W. Sewell, American Farm Bureau Federation, Chicago, Ill.

Forrest H. Shuford, State of North Carolina Department of Labor, Raleigh, N. C.

Florence C. Thorne, American Federation of Labor, Washington, D. C.

Mrs. John L. Whitehurst, General Federation of Women's Clubs, Washington, D. C.

Government advisers:

Dr. Maris Proffitt, U. S. Office of Education, Federal Security Agency, Washington, D. C.

W. J. Rogers, Department of Agriculture, Washington.

Martin F. Carpenter, Bureau of Employment Security, Federal Security Agency, Washington, D. C.

Mary H. S. Hayes, National Youth Administration, Federal Security Agency, Washington, D. C.

Clara M. Icyer, Division of Labor Standards, Department of Labor, Washington, D. C.

• EVENTS OF CURRENT INTEREST •

SUMMER COURSES FOR 1942

World Federation of Education Associations The World Federation of Education Associations (1201 Sixteenth Street NW., Washington, D. C.) will conduct a 5-week Institute on World Problems at the American University, Washington, D. C., July 12 to August 15. Three basic seminars will be held: Backgrounds of the War; Critical Evaluation of the Machinery and Means for International Cooperation; and Post-War Problems.

Courses Sponsored by N. E. A. The Department of Supervisors and Development from June 29 to August 10 National Education Association of the United States (1201 Sixteenth Street NW., Washington, D. C.) are sponsoring the following conferences:

July 6-17 Estes Park, Colo., with University of Denver. Subject: Group Planning and Problem Solving.

July 13-24 Florence, Ala., with State Teachers College. Subject: The School as the Community.

July 24-August 7 Chicago, Ill., with Commission on Teacher Education of American Council on Education, and University of Chicago. Subject: Human Development and Education.

Community Nutrition Institute The University of Tennessee announces a community nutrition institute and nutrition demonstration for health education, welfare, and other community workers participating in nutrition programs, June 8 to July 15, Knoxville, Tenn. The Children's Bureau of the United States Department of Labor is cooperating by making the services of one of its nutritionists available as a special lecturer. The institute will be under the direction of Dr. Florence L. MacLeod, from whom information can be obtained regarding enrollment, credit, and expenses.

Workshop in Community Nutrition A workshop in community nutrition will be conducted by the Department of Home Economics at the University of Chicago from July 27 to August 28. The Children's Bureau of the United States Department of Labor is cooperating again this year by making the services of staff members available as instructors. Information regarding this course can be obtained from the director of the course, Lydia J. Roberts, chairman of the Department of Home Economics at the University of Chicago.

Institute at New York School of Social Work The New York School of Social Work, Columbia University, offers three institutes during the summer quarter. Two of the courses scheduled for July 20-31 (Volunteers in the Defense Program and Public Medical-Care Programs) will be given by specially qualified members of the Children's Bureau staff.

Social Adjustment of Children

The Graduate School of Social Work of the University of Southern California, Los Angeles, is offering a 6-week course from June 20 to July 31 on Social Adjustment in Children and a 5-week course from August 1 to September 4 on Community Resources and Organization.

Child Development

Mills College, Oakland, Calif., is offering a summer course in Child Development from June 29 to August 8. This course is offered not only for undergraduate and graduate students who intend to specialize in the field of child development but also for persons already engaged in work with children. Observation of organized play groups for children and opportunity for directed teaching in nursery schools are provided for qualified students.

Sight-Saving Courses

The National Society for the Prevention of Blindness (1790 Broadway, New York) has announced that it is cooperating with the following colleges and universities in offering summer courses for the preparation of teachers and supervisors of sight-saving courses:

June 22-August 1 Peabody College for Teachers, Nashville, Tenn.

June 29-August 7 Wayne University, Detroit, Mich.

June 29-August 7 State Teachers College, Buffalo, N. Y.

July 6-August 14 Teachers College, Columbia University, New York.

Physical Therapy Program

A graduate program in physical therapy, sponsored by the American Physiotherapy Association, will be given at Northwestern University Medical School, Chicago, July 6-24. Courses will be given on human physiology, applied anatomy, and use of physical therapy in injury.

CONFERENCE CALENDAR

June 8-12 American Medical Association. Ninety-third annual meeting, Atlantic City, N. J.

June 10-12 National Society for Crippled Children. Conference meeting, Wilmington, Del. (This meeting replaces the annual meeting scheduled for October 18-20, as well as the institute scheduled for June 15-19.)

June 21-25 American Home Economics Association. Thirty-fifth annual meeting, Boston.

June 21-27 American Library Association. Sixty-fourth annual conference, Milwaukee.

June 22-24 Masonic Homes Executives Association of the United States of America. Twelfth annual conference, Wichita, Kans.

June 28-July 2 National Education Association. Eightieth annual convention, Denver.

June 28-July 3 American Physiotherapy Association. Twenty-first annual conference, Williams Bay, Wis.

The

CHILD

*** Monthly Bulletin ***

*Eighth Pan American Child Congress—
Declaration of Opportunities for Children
Action Taken by the Congress
Quotations From Addresses and Papers
Presented to the Congress*

* * *

Public Dining Halls in Mexico

* * *

Hospital Standards for the Care of Crippled Children

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

JUNE 1942



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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

EIGHTH PAN AMERICAN CHILD CONGRESS

Declaration of Opportunities for Children

Adopted by the Eighth Pan American Child Congress

FAMILY LIFE

OPPORTUNITY for every child to grow up within the loving care and affectionate discipline of family life.

To this end the creation of a family atmosphere suitable for the child's development is necessary and the following measures are essential:

(a) Every child should live in a family having an adequate standard of living and a stable economic foundation.

(b) The State should take measures to assure the economic stability of the family.

(c) It should be the concern of the State that homeless children be cared for in a suitable family environment.

(d) Only when the needs of homeless children cannot be met adequately in foster families should such children be placed in an institution.

(e) Poverty of the mother should not be a cause for complete separation from her child; welfare organizations should provide assistance to needy mothers until they can improve their economic circumstances through their own efforts.

HEALTH

OPPORTUNITY for every child to obtain the essential elements of wholesome, healthful living—good nutrition, healthful recreation, and sufficient rest—and to learn to give due value to physical, emotional, and intellectual development; not only from the point of view of his personal welfare, but of the welfare of those who surround him.

To this end it is necessary to safeguard the physical and mental health of the child from birth until the age at which he becomes a contributing member of the community, for which the following are required:

(a) Adequate diet.

(b) Periodic medical and psychological supervision, and adequate medical care during illness.

(c) Expert guidance in recreation.

(d) Adequate rest.

(e) Guidance in the proper formation of the personality, in all its aspects.

(f) Preparation for life in the community.

EDUCATION

OPPORTUNITY for every child to discover his special abilities, and to secure education and training to develop these powers—mental, physical, and spiritual—during the years necessary to achieve full development.

To this end it is necessary to provide appropriate education for each child in accordance with his age and mental capacity, such provision to include especially the following:

(a) Vocational guidance.

(b) Appropriate and adequate organization of intellectual, physical, spiritual, and cultural education during the time required for the attainment of maturity, and the full realization of his capacities and natural talents.

RESPONSIBILITY AND WORK

OPPORTUNITY for every child to develop responsibility and to learn to participate in the life of the community.

To this end it is necessary to provide opportunities for work, and to create a sense of personal responsibility under conditions appropriate to his age and capacity, employing such measures as:

(a) Teaching the child to control himself and to conduct his life in a manner that will enable him to assume appropriate responsibility at each stage of his development.

(b) Promoting child-labor legislation, fixing a minimum age for entrance into gainful employment, limiting the hours of work for children to a maximum of 6 hours a day, and establishing compulsory registration of employed minors under 16.

LEISURE TIME

OPPORTUNITY for every child to use creatively part of his free time in developing skills and practicing activities of his choice, individual as well as social.

To this end it is necessary to foster provisions for suitable recreation and leisure-time activities.

CITIZENSHIP

OPPORTUNITY for every child as a citizen to take his place in the life of the community.

To this end it is necessary to develop the conscience of the child concerning his obligation to contribute to the progress of the community and

to prepare himself for the responsibilities of citizenship, so that he may realize from his early years that the rights he enjoys in a democracy are accompanied by inescapable obligations which require the unselfish and socially desirable use of those privileges.

AND, FINALLY,

OPPORTUNITY FOR EVERY CHILD to take part, creatively, in transforming the raw materials of human life into usefulness or beauty—as artist or craftsman; as worker on the soil or in mine, mill, or factory; as a member of organizations for community betterment; or as scholar, scientist, or spiritual leader.

Action Taken by the Eighth Pan American Child Congress¹ Washington, D. C., May 2-9, 1942

The Eighth Pan American Child Congress met in Washington May 2 to 9, 1942, in accordance with the recommendation of the Governing Board of the Pan American Union and the recommendation of the Council of the American International Institute for the Protection of Childhood, and in conformity with an act of Congress of the United States.

Invitations to participate in the Congress were extended by the Government of the United States of America to the Governments of the other American Republics, all of which accepted and were represented by official delegations. Representatives of Government agencies and private associations, and other persons engaged in work relating to the health, education, or welfare of children, were also invited to participate in the Congress. A complete list of the delegates, numbering more than 150, together with their affiliations, will be published in the proceedings of the Congress.

The organizing committee, after consultation with organizations and individuals in the several Republics, formulated the program and regulations of the Congress, which were approved at a preliminary session of the official delegates held on May 2. The text of the regulations and agenda will be included in the proceedings of the Congress.

The major work of the Congress was carried on by the delegates meeting in general sessions.

Papers submitted to the Congress were reviewed in section meetings as follows:

- I. Health Protection and Medical Care.
- II. Education and Recreation.
- III. Economic and Social Services for Families and Children.

In addition to a committee on resolutions, four special committees were appointed to study the needs of children in wartime and in the post-war world, as follows:

1. Committee on essential services for mothers and children in wartime.
2. Committee on protection of mothers and children in danger zones.
3. Committee on plans for children in the post-war world.
4. Committee on Inter-American cooperation.

At the preliminary session of the official delegates Katharine F. Lenroot, chairman of the delegation of the United States and Chief of the Children's Bureau of the United States Department of Labor, was elected president of the Congress. At the same time Dr. Gregorio Arazo Alfaro, president of the American International Institute for the Protection of Childhood, was elected honorary president and the following were elected honorary vice presidents: Dr. L. S. Rowe, Director General of the Pan American Union; Dr. Roberto Berro, director of the American International Institute for the Protection of Childhood; and Dr. Hugh S. Cumming, Director of the Pan American Sanitary Bureau. The chairmen of the official delegations were named vice presidents of the Congress.

¹ This material is taken in part from the preamble to the Final Act adopted by the Congress.

The formal opening session of the Congress was held on the evening of May 2 in the Hall of the Americas of the Pan American Union, with the president presiding. An address of welcome on behalf of the Government of the United States was made by the Assistant Secretary of State, the Honorable Breckinridge Long, to which a response on behalf of the delegates was made by the chairman of the delegation of Mexico, Dra. Mathilde Rodrigues Cabo. On this occasion addresses were also delivered by Dr. L. S. Rowe, Dr. Hugh S. Cumming, and Dr. Roberto Berro. A message from the president of the Institute, Dr. Araz Alfaro, was read by the delegate of Argentina, Dr. Mario H. Bortagaray.

As a result of its deliberations the Eighth Pan American Child Congress approved resolutions and recommendations proposed by the four committees of the Congress and a number of other recommendations, all of which are included in the Final Act of the Congress, signed on May 9 in the four official languages of the Congress—Spanish, Portuguese, French, and English—by the chairmen of the delegations from the 21 American Republics.

The report of the committee on plans for children in the post-war world includes a Declaration of Opportunities for Children which is reproduced on page 297 of this issue.

The recommendations brought in by the committee on protection of mothers and children in danger zones, the committee on essential services for mothers and children in wartime, and the committee on inter-American cooperation, which were approved by the Congress and included in the Final Act, are as follows:

RECOMMENDATIONS ON PROTECTION OF MOTHERS AND CHILDREN IN DANGER ZONES

The Eighth Pan American Child Congress

Recommends to the Governments of the American Republics the desirability of appointing committees on the protection of mothers and children in wartime, or entrusting these duties to existing organizations, beginning the work with a census and identification of the child population;

That said committees begin an immediate study of the problems and measures necessary for evacuation from danger zones, so that each country may be in a position to offer the best possible protection to mothers and children as a first measure in a program of civil defense.

That the American International Institute for the Protection of Childhood, through the Children's Bureau of the United States Department of Labor, make available all the reports of its work in this field of protection of

mothers and children, that it send questionnaires periodically to the several American Governments in order to learn the work that they are doing, and that it instruct the representatives whom the countries may send for training.

RECOMMENDATIONS ON ESSENTIAL SERVICES FOR MOTHERS AND CHILDREN IN WARTIME

The Eighth Pan American Child Congress

Resolves to recommend the following:

1. *Measures to maintain and extend, in time of war, health services for mothers and children.*

1. The intensification of preventive health work, especially in the following ways:

- (a) Immunization against communicable diseases.
- (b) Treatment of syphilis during pregnancy.
- (c) Sanitation of unhealthy areas and control of drinking water.
- (d) Sanitary control of foodstuffs, especially milk.

2. Intensification of health education for mothers.

3. Increase of medical supervision and education for expectant mothers and for children from birth to adolescence by means of prenatal clinics, postnatal clinics, and school health services, including instruction in first aid.

4. Improvement and supplementation of the diet of women during pregnancy and lactation by means of special restaurants and other methods.

5. Increase in provision for medical and obstetric care during childbirth.

6. Special attention to nutrition by the creation in each country of a committee to study and try to solve the following problems:

(a) Determination of the most adequate types of diet from the standpoint of nutritive value in accordance with the conditions prevailing in the country and for different ages, taking into consideration the natural products of each country.

(b) Determination of the most adequate types of diet from the standpoint of cost and economic conditions of the population.

(c) Determination of the best form of nutrition education directed toward the establishment of improved food habits.

(d) Intensification and amplification of the program for milk stations and school breakfast and lunch services.

7. Creation of behavior clinics and development of educational measures to counteract the psychological effects of the war on children, utilizing for this work the services of physicians, psychiatrists, psychologists, teachers, social workers, and parents.

8. Promotion of the most rapid preparation of volunteer personnel to assist the technical personnel in the medical care of mothers and children.

9. Preparation of a plan for the mobilization and distribution of medical specialists in obstetrics and pediatrics, and of nurses in order that the medical services for mothers and children may not lack technical guidance.

10. Study of the form of raising official and private funds for the maintenance and extension of medical services for mothers and children.

II. *Measures for maintaining and extending in times of war the educational and recreational services and regulation of the work of minors.*

1. Stimulation of the creation of new educational provisions from the kindergarten to the university, as well as special educational institutions for abnormal, blind, deaf and dumb, and crippled children.

2. Direction of education toward obtaining development of children as individuals, capable of taking care of themselves and devoted to freedom and peace.

3. Endeavor through educational means to arouse in children a sense of social solidarity, conscientious discipline and intelligent loyalty, and to inculcate moral and ethical principles.

4. Utilization of the school as an auxiliary to the civil-defense organization under its direct control.

5. Promotion of the installation of recreation centers and children's libraries and the formation of clubs, and social and recreational organizations that may provide for the children the means of a sound and wholesome relaxation and character development.

6. Encouragement of the theater, children's literature, and other artistic activities.

7. Promotion of child-labor legislation and regulations, including provisions for minimum age for entrance into employment, working conditions, wages, maximum working hours, and regulation of the work of children in street trades.

8. The promotion of the creation of offices that may be entrusted with the supervision of the work of minors and with the enforcement of laws and regulations in regard to the same.

9. Provision of adequate facilities for the training of teachers, recreation leaders, and enforcement officers.

III. *Measures to obtain the economic stability of the family and to maintain and extend social services for children under the conditions created by the war.*

1. Guidance and encouragement of industrial and agricultural production in each country, under the guidance and with the aid of the Governments, taking into consideration the needs of defense and production of war materials, as

well as internal consumption needs, and the possibilities of foreign markets.

2. Development of an employment policy, consonant with the economic and production program planned, and the establishment of central employment services, giving preference in placement to men and women who are heads of families, and avoiding as far as possible the employment of mothers of very young children who need their care.

3. Provision for vocational training for workers in new industries and activities, securing for women heads of families, after they have had vocational training, ample opportunity for employment, especially in types of work from which men are being transferred for employment in new defense industries.

4. Establishment of an adequate minimum wage to guarantee the subsistence of the family unit and reasonable working hours.

5. Broadening social-security services and savings plans to provide subsistence for workers and their families in certain eventualities and contingencies (maternity, illness, invalidism, death, unemployment).

6. Application of measures to reduce the high cost of articles of prime necessity, with rationing and adequate distribution of food, under government control, when circumstances require, with special consideration of mothers and children.

7. Development of a broad educational program for the improved utilization of food-stuffs and study of low-cost diets.

8. Application of measures to provide low-cost housing to improve hygienic conditions, and to extend the construction of adequate and low-cost homes for workers.

9. Development of social services for children based on regard for the family unit, or the creation of an adequate home environment for those lacking such advantages, giving special attention to:

(a) Creation or increase of facilities and services for the children of working mothers, including the provision of school breakfast and lunch services for such children.

(b) Placement of dependent children in family homes.

(c) Economic aid to dependent children in their own homes.

10. Development of legislation and regulations to determine:

(a) The responsibility of the government in the social protection of children.

(b) The responsibility of fathers toward children, both legitimate and those born out of wedlock, and the development of measures to enforce this obligation.

(c) Measures facilitating adoption or placing of dependent children.

(d) Principles of treatment and education of socially maladjusted children.

11. Promotion of the training of social workers, who constitute personnel indispensable to the advancement of the program as a whole, establishing additional schools of social work as required.

12. Establishment of a system of government allowances to provide economic security for the families of men in the armed services.

13. The Governments of the American Republics should, within their economic possibilities, provide such additional funds as may be necessary to carry out these recommendations.

RECOMMENDATIONS ON INTER-AMERICAN COOPERATION

The Eighth Pan American Child Congress

Recommendations that:

1. The American International Institute for the Protection of Childhood should be constituted the permanent organization of the Child Congresses, charged with the responsibility of carrying out, so far as possible, their resolutions and recommendations; and should be recognized through official action of the American Republics as the center for scientific study and cooperative action in relation to matters affecting the health, education, and welfare of children. Its work should be closely related to the work of other inter-American organizations, especially the Pan American Union, technical agencies set up under the auspices of the Pan American Union, and the Pan American Sanitary Bureau.

Prior to the Ninth International Conference of American States, the Institute should review and codify all the actions taken by international American conferences affecting cooperation in child welfare and related fields and present a comprehensive proposal to the Ninth International Conference of American States, which would give an ample basis for the work of the Institute and the cooperative activities of the American Republics in matters relating to children.

2. The seats of future Pan American Child Congresses should be designated by agreement of the Governing Board of the Pan American Union and the Executive Council of the American International Institute for the Protection of Childhood.

3. The dates of the Congresses should be fixed by the Government of the country designated as the seat, after consultation with the Pan American Union; the Institute should prepare the regulations and program of the Congress in agreement with the organizing committee of the country which is the seat of the Congress.

4. With a view to securing increased support for the Institute through encouraging member-

ship and more adequate financial support by Governments, the Institute should make a comprehensive annual report to the Governing Board of the Pan American Union, in order that the Governing Board may be in a position to take appropriate action and to suggest ways in which the work of the Institute may be strengthened. Arrangements should be made in collaboration with the Governing Board of the Pan American Union for consideration of reports and recommendations of the Institute and the International Conference of American States.

5. The delegates to the Eighth Pan American Child Congress on their return to their respective countries, should take all possible steps to secure the adherence of their countries—if they are not already members of the Institute—and payments of annual quotas.

6. The annual quotas for the several countries should be fixed on the basis of a classification of Governments according to population, subject to modification in accordance with the economic situation of each country. Subject to such modification, it is suggested that the smallest annual quota be \$200 and the largest \$10,000.

7. In addition to the payment of quotas it is urged that Governments members of the Institute be requested to authorize the assignment of technical personnel to assist the Institute in carrying on special projects of particular value to the Governments concerned. These projects would ordinarily require visits of committees or technical personnel to various countries for the purpose of investigations and advisory service.

8. The International Council of the Institute should be reorganized in accordance with the following principles:

(a) The Government of each country having membership in the Institute should designate as a member of the International Council an official whose responsibilities include services to children; these members of the International Council should be assisted in their respective countries by a committee of advisers appointed by the Government representing the different fields of child welfare, including pediatricians and experts in child health, education, and social work; in countries where a committee has been organized to work in preparation for the Eighth Pan American Child Congress, the Government might wish to consider the desirability of giving the committee a permanent character for the purposes indicated, with such modifications in membership as may be desirable.

(b) As a general rule the Pan American Child Congresses should meet every 4 years, and the International Council every 2 years, one of these meetings being held at the same time and place as the Pan American Child Congress; in each biennial session an executive committee composed of one member from each of seven countries should be elected to serve until the next meeting of the International Council, a member being permitted to designate an alternate

stationed in Montevideo for service at meetings of the executive committee which it is impossible for him to attend; the executive committee shall have all the powers of the International Council between meetings of the International Council, including the selection of a director of the Institute and approval of a program of work.

(c) It may be desirable to form regional subcommittees composed of members of the International Council, which shall be charged with the development of special regional cooperative activities.

9. A definite program of work of the Institute should be outlined for a period covering not less than 4 years and should be subject to such modifications as necessity may require; on the basis of this program the International Council or its executive committee should be authorized to seek special support from private sources as well as from Governments.

10. Subjects of immediate importance for consideration of the Institute are the following:

(a) Study of the nutrition problems of the children of the Americas, utilizing the facilities offered by the Republic of Argentina, the United States of America, Cuba, and other countries of the continent, and carrying on the work in cooperation with the Pan American Sanitary Bureau and other inter-American and national agencies.

It is suggested that a traveling commission might be organized composed of experts in nutrition and including physicians, public-health nurses, and social workers whose services would be made available by their respective governments and who might be able to conduct a traveling inquiry concerning the nutritional needs of the children of the Americas and the ways in which the resources of the countries might be organized to meet these needs.

(b) A study of the ways in which the education of the mothers of the American Republics in matters relating to child care might best be organized and the extent to which educational material in the form of motion pictures, radio programs, and publications might be made available through inter-American collaboration.

(c) Study of the methods of civil protection of children in countries engaged in the war or threatened by attack, and the ways in which inter-American co-

operation might be organized to safeguard children from the dangers of war.

(d) Studies of special problems such as the care of children of sick parents (tuberculous, leprosy, and so forth); study of the methods of placing children in family homes and the improvement of methods employed for institutional care of children; systems of family allowances; and study of vital statistics, in agreement with the Pan American Sanitary Bureau.

11. That the Institute serve as an information center concerning fellowships available for study in the various American Republics in fields related to child welfare, including fellowships for public-health nurses and social workers, and as a center for recommendations to be made to the appropriate agencies concerning the development of a comprehensive fellowship program.

12. That the Institute cooperate with other inter-American agencies engaged in making plans for the reconstruction of the economic and social life of the American Republics in the post-war period.

13. That the Governments of the American Republics possessing greater technical experience in the protection of childhood render assistance, through official or private institutions, to countries which may require such assistance.

* * *

Resolutions introduced separately and adopted by the Congress deal with standards of child placement, the extension of health services for mothers and children, services for children handicapped by poliomyelitis or other disabling diseases, sanitary and social measures for rural families, priority in the transportation of foodstuffs for children, supervision over commercial vitamin preparations, sanitary measures to safeguard the milk supply, and the promotion of inter-American understanding through special courses of study in the educational system.

It is my great pleasure to extend a most cordial welcome to the delegates from the American Republics to the Eighth Pan American Child Congress. * * *

Your deliberations and the firmness of your purpose to apply to the practical concerns of everyday life the principles which you will here declare, will contribute in great measure to the extension and fulfillment of the good-neighbor policy as the basic principle of international association.

From the message of Franklin D. Roosevelt, President of the United States of America.

Quotations From Addresses and Papers Presented to the Congress

It is possible for us to hold this Congress because of the greatness of the vision and the nobility of the sacrifice of Bolivar, San Martin, Washington, Jefferson, and the other heroes of the wars of independence in every American country. They and their followers and successors, from all walks of life and of diverse racial and national origins, laid the foundations of a civilization that cherishes human life for its own sake, and because it finds its source and meaning in God. In such a civilization the interests of children are primary. When we fight for the freedom of the Americas we are striving to make secure a future for which children must today be prepared. We cannot put aside until after the war our concern for children. The growth and development of a child does not wait upon convenience but is determined by the conditions in which his life unfolds. Ours is the twofold task of assuring a future fit for our children and rearing children fit for a future which shall be built upon foundations of justice, freedom, security, and mercy for all. * * *

Besides its spiritual strength and unity, the

Congress is notable because its deliberations have been conducted under the inspiration of a steadily developing concept of inter-American community of interest, a concept which is taking form in official conventions, agreements, and resolutions adopted by conferences of authorized representatives of the American States. This concept is not new, but is an expression of the aspirations of the long line of Americans of Latin and Anglo-Saxon origin who saw clearly the necessity for cultural as well as political and economic relationships among the peoples of the New World. Thus, inter-American work in behalf of children finds its foundation in the mutuality of interest of free nations, having a common stake in a world order based upon the principles of the Atlantic Charter, an order in which the promotion of the happiness and welfare of men and women and little children will be the central aim of all political and social institutions and arrangements.

—KATHARINE F. LENBOOT,
Chief, Children's Bureau,
U. S. Department of Labor.

It having been impossible for me to be present at this Congress, of such importance to our continent, and to deliver as requested the inaugural speech, I crave your permission first of all to convey my deep gratitude for this, the signal honor so kindly paid me by the organizing committee and at the same time to transmit my most cordial greetings and best wishes for the success of this great assembly of friends and benefactors of children. * * *

It would have given me much pleasure to have been able to appreciate at close range the progress attained by the Nation which has made the greatest efforts in favor of child health and welfare and to spend a few days together with the most eminent puericulturists and educators of the American countries. And since it is unfortunately impossible for me to do this, I herewith convey my most earnest hope that in this further meeting you may be able to study all the problems connected with infant welfare more profoundly still, were that possible, under the leadership of the United States specialists and be successful in better coordinating the most efficacious collaboration

between all our nations," thereby strengthening still further the bonds of American fraternity and consolidating the solidarity of the nations of this continent, united as they are already in the high ideals of liberty, work, progress, human affections, and social justice.

And may I conclude these words, simple though they be but fraught with sincerity and the noblest American spirit, with the admonition addressed by a great American woman, Grace Abbott, a worthy predecessor to our present president in the Children's Bureau, to the members of the third White House Conference: "Before we break up, promise me, each one of you, solemnly, to work more intelligently, with still greater zeal, on behalf of the children."

So be it, for the sake of the happiness and increased material and moral greatness of our America!

*From the message of Dr. Gregorio Araoz Alfaro,
President of the American International Institute
for the Protection of Childhood, Montevideo,
Uruguay.*

It is most encouraging that in these difficult times the peaceful processes of mutual collaboration of free peoples for the purpose of promoting the welfare of their children may go on unabated. This series of conferences, of which this is the eighth, was inaugurated over a quarter of a century ago during the first World War. In war as in peace, the peoples of the American Republics are convinced that the welfare of their children is of paramount importance. While the children of the independent nations which have been ruthlessly overrun by the Axis countries are undergoing malnutrition and are being subjected to privation and suffering, the free democracies of the Americas are meeting in one of their periodic conferences to formulate plans for their children's welfare, and at the same time the armed forces of these Governments are taking steps to secure for them a decent future. * * *

You have undertaken, therefore, a heavy responsibility to plan for the protection of children of the Americas during the present emergency and to strengthen the foundations for a great continental program to assure for them their birthright of peace, freedom, health, and security. Your task will be facilitated and your efforts encouraged by the splendid opportunity of friendly collaboration and mutual respect which happily prevails among the free nations of the Americas.

—THE HONORABLE BRECKINRIDGE LONG,
Assistant Secretary of State,
United States of America.

* * *

The problems of child welfare have one aspect that is common to all the nations and another that is characteristic of each country. Local action must be stimulated to erase these differences so that we can concentrate our efforts on problems that are common to all and in full cooperation throughout the Americas, strive to keep the child untouched by the dangers that threaten the normal development of his physical, moral, and spiritual being.

The American International Institute for the Protection of Childhood seeks to perform a comprehensive and thorough service in behalf of the American child, with the support of the Governments and the people. * * *

The Institute, whose life is bound up with these Congresses, will gather up the suggestions which result from our meeting and the echoes of our deliberations, to give them unity and publicity in its Bulletin.

—DR. ROBERTO BERRO,
Director, American International
Institute for the Protection of
Childhood, Montevideo, Uruguay.

In the face of the tragic period through which the world is now passing I consider it necessary to arrive at an inter-American understanding in order to study and seek a solution of one of the most serious problems of the post-war period—nutrition of the people.

There can be no real solution without at least an approximate knowledge of each country's actual needs and of the special regional needs within each country. To this end technical personnel must be trained and where this is not possible technical collaboration from other countries is imperative. The general practitioner and the ordinary public-health expert cannot supply the necessary information. The problem is highly complex and embraces the basic economy of the country, agriculture, animal husbandry, and international relations on the one hand and, on the other, knowledge and the possible solution of those points in direct relation to biology and the social economy of human nutrition.

—Excerpt from paper submitted to Section III
by PROF. PEDRO ESCUDERO, Director General
of the National Institute of Nutrition,
Buenos Aires, Argentina.

* * *

God forbid that the swift and gracious human reaction which makes all civilized people kindly toward children should ever die out. But with it must go cooler, more analytical treatment of the basic problem—an organized, disciplined attack upon those conditions, social, intellectual, and moral, which lie at the roots of the misfortune of children.

So began the scientific phase of children's work. It has been a long and fruitful period—and is far from being ended. Through it have come major advances: in the field of medicine and medical care for mothers and infants, and children and adolescents. As a result of it, there have come the beginnings of an organized body of knowledge in the fields of psychiatry and child psychology. In jurisprudence and law we are gradually learning to adapt the old procedure of the police and criminal courts to the newer technique of studying children as individuals, and of endeavoring to correct delinquency exactly as a doctor tries to correct a physical ailment. Our schools have become centers in which not merely the minds of children are taught, but in which their bodies could be strengthened, their nutrition guided, and their awareness of the community could be increased. Our industry is at length learning, and our laws are beginning to assure, that children shall not become industrial cannon-fodder.

—A. A. BERLE, JR.,
Assistant Secretary of State,
United States.

The theme, inter-American cooperation for child welfare, is always of interest but more so than ever today when forces of destruction and evil rule the world. For child welfare is not a distinct discipline but rather the combined and harmonious result of all activities which seek the greater good of our American children. Very often the problem is viewed from specific angles with detriment to the whole solution. With the greatest good will, the physician sees in the child an object of prophylaxis or therapeutics; the lawyer sees only the legal aspects; the teacher sees education as the single goal. This should not be. I have repeatedly said that the child needs each of these things and many others, but he needs them all, for his true welfare is served only by bringing them all into harmony just as the notes blend and follow each other in the harmonious melodies of a song.

—DR. VÍCTOR ESCARDO Y ANAYA,
*Secretary of the American International
Institute for the Protection of Child-
hood, Montevideo, Uruguay.*

* * *

In view of the fact that the new economic situation created by the war will have an important influence on the family and the child, and the fact that the future of America depends primarily on the new generations which will be made up of these children, since they are the men of tomorrow whose duty it will be to practice the principles of democracy for which the continent is now fighting, it should be our endeavor to unify our ideas on the essential measures which all the countries should undertake as soon as possible in order to avoid intensifying the economic crisis through which we are now passing, thereby bringing a greater degree of disequilibrium into society, which might bring on the total bankruptcy of family life and accentuate the conditions of misery and abandonment in which a great number of children are born and grow.

—DRA. MATHILDE RODRÍGUEZ CABO,
*Médica, Directora de Asistencia Infantil,
Secretaría de Asistencia Pública, México.*

* * *

Not only has this been a week of intense scientific effort but, more than that, it has been a week during which the 21 countries of America, working together toward a common purpose, have made clear to all the world that the words inter-American solidarity and cooperation have on our lips a warmth of sincerity and loyalty and, above all—with the wonderful example before us of this great Nation at war, united, organized, brave and impregnable, now fighting in defense of the sacred principle under which we were all born—democracy. * * *

And above all, we may say that these unhappy times have served to show that America as a whole, united in the midst of war, bends its efforts to the peaceful task of solving the problems of childhood with a generous spirit and with a grasp of historical perspective which reveals faith in the future, confidence in our own efforts, and clarity in our ideals.

—DR. MARIO H. BORTAGARAY,
*Director of Child Welfare,
Buenos Aires, Argentina.*

* * *

Wartime conditions are now speeding up the development of new industries in the South American countries and the evolution away from the economic status of exporters of raw materials dependent upon other countries for finished products. * * *

The present programs of stimulating food consumption and production in the United States include direct free distribution of surplus products to relief clients, the food-stamp plan, school lunches, and "nickel-a-quart" milk programs for relief families and "penny-a-glass" milk programs for school children. Eight million relief clients and six million school children are now having their diets supplemented through these programs. There are similar extensive school-lunch programs in Argentina, where over a third of the school children receive some supplemental meal, and in Uruguay, where over one-fifth of all school children are reached. Dental difficulties and skin diseases have declined noticeably since the school lunches were started. Uruguay, Chile, Colombia, Brazil, Peru, Venezuela, Mexico, Ecuador, Costa Rica, Paraguay, Cuba, and Nicaragua all have breakfast or lunch programs for undernourished children, maintained by public subsidy or private charity.

As the system of government subsidies for adequate nutrition is extended, it might be made even more effective by trading food surpluses of one country, such as wheat, beef, or sugar, for surpluses of other countries, such as cocoa or bananas, to the advantage of the school children in both.

—MORDECAI EZEKIEL,
*Economic Adviser to the Secretary of
Agriculture, United States.*

* * *

The things that we consider basically important for children form, by their very nature, the foundation for all that is significant in civilization as it has developed in different cultures and in different ways. The preservation and advancement of the means by and through which children are allowed and expected to develop their potentially creative capacities becomes the

reason why we will fight those forces in the world which seek to destroy what we know is important, whether those forces stem from ignorance or greed or from those which come from the enemies with whom we are now at war.

—FREDERICK H. ALLEN, M. D.,
Director, Philadelphia Child Guidance Clinic,
United States.

This Child Congress has a singular and great importance because there will be discussed here not only the care of the child's health and his protection against physical and chemical attacks by the enemy, but also the defense against any system tending to diminish or impair one's own judgment.

These meetings should formulate standards for an education of children which would train the minds of the children of today so that they may be able to develop fully within the democratic principles of the future.

—DR. ENRIQUE SALADRICAS,
Director General of the
Finlay Institute, Cuba.

* * *

We have learned, even as we fight a war of machines, that real strength is people. A nation's strength is the sum of all the people and groups of people in the country. Our civilian mobilization is a mobilization of people—to get the goods out, to get the materials in, to make the community efficient and strong by solving its housing, sanitation, conservation, transportation, recreation, and health problems, to make the community secure by providing protection against air raids that may come, rumors that are whispered, economic and psychological stresses of all kinds, to make the family secure by insuring as fully as possible the health and well-being of every member, to forge the little strengths of every man, woman, and child in the Nation into one great strength that will take the natural resources of the continent and scourge the powers of organized evil from the earth.

—JONATHAN DANIELS,
Assistant Director, Office of
Civilian Defense, United States.

INTER-AMERICAN NOTES

Eleventh Pan American Sanitary Conference

The Brazilian Government has decided to sponsor the Eleventh Pan American Sanitary Conference and has invited the Government of the United States to be represented at the Conference, which will be held in Rio de Janeiro, Brazil, probably from July 4 to July 15, 1942.

(Official correspondence.)

Public Dining Halls in Mexico City

In line with the inter-American movement for improved nutrition the Government of Mexico has recently taken measures to provide more wholesome food for the low-income groups and for education of the people in the principles of nutrition. The medium selected is the public dining hall, several of which have been established in Argentina, Chile, Peru, Uruguay, and other South American countries.

On December 2, 1940, the President of Mexico issued an Executive Order calling for the establishment of a system of dining halls to provide nutritious meals at nominal cost to persons with a small income and to serve as centers of education in nutrition. The President ordered that these dining halls be opened in the crowded sections of the Federal District, which includes Mexico City, and in the National Territories (parts of the country not admitted to state-

hood). The setting-up of the dining halls was entrusted to the Department of Public Welfare (Secretaría de la Asistencia Pública).

Before the opening of the first dining hall leaflets were distributed in the neighborhood stating the purpose of the dining hall and the rules governing its use. Social workers employed by the Department of Public Welfare visited the families in the neighborhood to arouse their interest.

The economic condition of each family applying for admission to the dining hall is investigated by a social worker; its food habits are studied by a dietitian; and each member of the family is given a physical examination. Persons with contagious diseases are barred. If evidences of malnutrition are found, efforts are made to ascertain the cause. If improper diet was brought about by economic conditions, the family is admitted to eat in the dining hall; but if malnutrition is attributed to faulty distribution of the family income, or to ignorance or bad habits, the family is not admitted to the dining hall, but a social worker or nurse-dietitian is directed to give the family the necessary advice.

Although originally the dining hall was intended mainly for children because of the importance of proper food for their development, the employment of many mothers outside the home resulted in the decision to open the dining

hall to whole families; unattached persons are also admitted. Photographs of the persons entitled to eat in the dining halls are attached to the cards of admission.

An income within specified limits is another requisite for admission; persons with an income below the prescribed minimum may be admitted, or may be referred to a special branch of the Department of Public Welfare; those with an income above the maximum are considered not to need the service. Persons making a living by begging or other questionable means are barred. The charges for the meals vary according to the family income and are intended not to cover the cost of food but to preserve a sense of responsibility on the part of the head of the family; in some cases the meals are free. It has been pointed out by the Department of Public Welfare that with this method of selecting clients the dining hall does not compete with private business.

The diet adopted in the dining hall was determined by the Committee on Food (Comisión de Alimentación) of the Federal Department of Public Welfare (Secretaría de Asistencia Pública). The average daily diet has an energy value of 2,700 calories and includes 115 grams of protein.

A typical menu for three meals:

Breakfast:

Eggs—2 for an adult and 1 for a child.
Fruit—banana.
Rolls.
Milk— $\frac{1}{2}$ pint.

Noon meal:

Vegetable soup.
Rice.
Meat— $\frac{1}{4}$ pound.
Green vegetable salad.
Fruit—1 orange.
Rolls.

Tortilla (a cornmeal pancake).

Evening meal:

Pea soup.
Beans.
Milk— $\frac{1}{2}$ pint.
Rolls.
Tortilla.

In order to ascertain the effect of this food physical and dental examinations and laboratory tests are given every 3 months to the clients of the dining hall. If illness is discovered the patient is referred to the social worker, who directs him to the public clinic.

In the last week of January 1942, 239 families consisting of 1,110 persons bought cards; nearly three-fourths of these persons were children less than 16 years of age. The children were given a mental test in addition to the regular medical examinations required of each applicant; the quality of their school work at the time of their

admission was also reviewed. The data obtained in these examinations are to be used as a basis for subsequent comparisons in determining the effect of the food.

The first dining hall, opened in November 1941, is situated in a modern building built for a market but never used for that purpose. The entrance leads to a waiting room, cloakroom, and washrooms (separate for men and women) with running water for washing the hands but without individual washbowls (which are considered insanitary), and with special fountains for cleaning the teeth. Nearby are offices of the examining physician, dentist, social worker, and nurse; there are also a laboratory and a nursery where children too young to eat in the dining hall are cared for while the mothers are eating. Back of these rooms is an office where the cards of admission are presented. This leads to the food counter and steam tables, coffee urns, milk containers, and drinking fountains. The center of the building is occupied by the dining hall which has a seating capacity of 300. Four seatings can be accommodated for each of the 3 daily meals.

The cafeteria system was adopted after a careful study because it permits orderly, rapid, and convenient service to a large number of people without a large staff of employees. Each family is assigned a private table whenever possible.

The dining hall, directed by trained technicians, is said to be rendering an important service in teaching the people, particularly the children, to eat wholesome food and in helping them to develop habits of personal cleanliness.

Plans are made for educational work through lectures and literature to reach housekeepers, particularly mothers, and persons planning meals in institutions and schools.

On March 25, 1942, the cornerstone was laid for a second dining hall in a thickly populated neighborhood. This dining hall will have a seating capacity of 1,200 and 2 seatings are planned, so that 2,400 persons will be served at each meal. Attached to the dining hall will be a day nursery for 200 children under 3 and a kindergarten where 100 older children can be cared for during their mothers' absence at work.

The program of the Department of Public Welfare for 1942 calls for the construction of two additional dining halls.

A. K. S.

Sources.—Asistencia, Órgano de la Secretaría de Asistencia Pública, September–December, 1941; Secretaría de la Asistencia Pública, Informe de Labores Presentado al H. Ejecutivo de la Unión, 1940–41, Mexico; El Popular, Mexico City, various issues; and Los Comedores Nacionales de Mexico, by Dr. Francisco de P. Miranda, paper presented at the Eighth Pan American Child Congress, Washington, May 2–9, 1942.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

Hospital Standards for the Care of Crippled Children

BY A. L. VAN HORN, M. D., AND ARTHUR J. LESSER, M. D.

Division of Health Services, U. S. Children's Bureau

During the past 6 years, considerable progress has been made on all fronts in the development of State services for crippled children. Methods for locating children in need of care have been improved; diagnostic-clinic services have been extended, with particular emphasis upon provisions for reaching children residing in rural areas and in areas of special need; improved hospital and treatment facilities have been developed; provisions for care during the convalescent period have been strengthened; general medical (pediatric) services have been more generally utilized in the care and supervision of children admitted to hospitals, convalescent homes, and foster homes; and standards for qualifications of professional personnel have been raised in all sections of the country. Although every State agency administering State services for crippled children has experienced an increase in the number of children accepted for care, emphasis has been placed upon quality of services rather than upon quantity.

Prior to the development of the Nation-wide services for crippled children under the provisions of the Social Security Act, relatively few of the State agencies which were administering these services had assumed responsibility for establishing standards for the selection of hospitals to be used for the care of crippled children. In general, however, these State agencies used principally the best hospital facilities available within the State, usually located in large urban communities. With the expansion of these services on a State-wide basis and an increase in the number of children accepted for care, there was need for utilizing the facilities of additional hospitals in different sections of the State.

At the present time, hospital care is being provided for crippled children under approved State plans in more than 700 hospitals. During

the calendar year ended December 31, 1941, some 1,488,000 days care were provided in these hospitals for 31,153 crippled children.

As a matter of public policy it seems reasonable to expect that when a public agency has been charged with the responsibility for expending public tax funds for the purchase of hospital care it should purchase such care only from hospitals meeting standards which are acceptable to the public agency. Such standards for the selection of hospitals should be established by the agency and should be made known to the hospitals within the State. The selection of hospitals used for the care of crippled children under State plans approved by the Chief of the Children's Bureau has been based upon such standards adopted by State agencies.

Early in the development of the program for crippled children, in order to serve as a guide to State agencies, the Children's Bureau Advisory Committee on Services for Crippled Children gave careful consideration to such standards and made the following recommendations at its meeting held October 9-10, 1936:

The following should be considered minimum standards for hospital care of crippled children under the Social Security Act:

(a) A hospital used for services for children suffering from orthopedic conditions should have on its staff a physician who is certified by the American Board of Orthopaedic Surgery or is eligible for such certification.

(b) Such a hospital should have on the staff of its in-patient or out-patient department at least one physical therapist. All physical therapists employed should be registered by the American Registry of Physical Therapy Technicians or eligible for such registration. The physical therapists should be responsible to the surgeon in charge.

(c) Such a hospital should have on its staff at least one qualified nurse with experience in pediatric and orthopedic nursing.

(d) A hospital used for services for crippled children

should conform at least with the minimum standards established by the American College of Surgeons.

(e) Such a hospital should employ on its staff at least one qualified medical-social worker.

(f) Physical-therapy equipment should include a room equipped with at least an exercise table and some form of radiant heat.

At the meeting of the Advisory Committee held on April 7 and 8, 1937, the following recommendation was made pertaining to standards for the selection of hospitals to be used for crippled children under State programs:

Registration of hospitals by the American Medical Association was recommended as an additional safeguard to the desirable standards formerly suggested by this committee.

Again at its meeting held on December 2, 1938, the Advisory Committee considered the problem of hospital standards and made the following additional recommendations:

That any hospital used by State agencies should provide adequate facilities for the detection and isolation of children suffering from communicable diseases and those contracting such diseases during the period of hospitalization.

That hospitals and convalescent institutions used by State agencies in caring for crippled children should be regularly inspected for fire hazards and should comply with the minimum requirements of the State law with respect to adequate fire protection.

At its meeting held on March 4, 1940, the Advisory Committee considered provisions for general medical supervision of children in hospitals and made the following recommendation:

That a hospital used for services for crippled children should provide facilities not only for orthopedic care but also for pediatric supervision and consultation and for consultation in other specialties.

At this meeting special consideration was given by the Advisory Committee to standards for the selection of hospitals used by State agencies for the care and treatment of children suffering from heart disease or conditions leading to heart disease. The recommendations made by the Committee follow in general the recommendations quoted above but are adapted to the special services indicated for children with rheumatic fever and heart disease. These recommendations may be obtained from State agencies administering services for crippled children or from the Children's Bureau, Washington, D. C.

In the light of the recommendations quoted above, it is interesting to observe the standards that have been adopted by State agencies for the selection of hospitals used under the State programs and included in the State plans approved by the Chief of the Children's Bureau for the fiscal year 1942. Such standards have been given in the State plans for all States and Territories except Alaska, District of Columbia,

North Carolina, and Puerto Rico. It is known, however, that in these four States and Territories only hospitals approved by the American College of Surgeons are being used for the care of crippled children. Standards adopted by the remaining States and given in State plans are as follows:

<i>Hospitals must be approved by—</i>	<i>Number of States</i>
American College of Surgeons.....	41
American Medical Association (registration).....	18
American Hospital Association.....	6
State hospital association.....	3
American College of Physicians.....	1

Some State agencies may require approval by more than one of these organizations.

It is encouraging to note the large number of State agencies requiring approval by the American College of Surgeons. States where such approval is not required are usually found to be those using the only available hospitals in the State which accept Negro patients but which have not as yet been able to meet the minimum standards of the American College of Surgeons. However, progress is being made in developing the facilities and services in these institutions and each year shows a decrease in the number of hospitals used which are not so approved. Reference to approval by national organizations other than the American College of Surgeons has little significance as this is the only agency that operates an annual inspection service upon which approval is based.

All too frequently there is a tendency for public agencies to think solely in terms of minimum rather than optimum standards. If continued progress is to be expected in raising the standards of care to be provided for crippled children in hospitals mere effort will have to be given in the future to desirable standards other than approval by the American College of Surgeons. Such approval unquestionably serves as an important safeguard in the selection of hospitals but offers no assurance that the hospital so approved is especially equipped to provide services for crippled children.

A number of State agencies have given recognition to the needs for certain additional requirements. A recent review of State plans for the fiscal year 1942 revealed that in 31 States additional standards had been included for the selection of hospitals. These are:

<i>Requirement</i>	<i>Number of States</i>
Adequate orthopedic equipment.....	11
Orthopedist on hospital staff.....	8
Certified orthopedist on hospital staff.....	5
Orthopedist or plastic surgeon on hospital staff.....	2
Orthopedist or pediatrician on hospital staff.....	1
Orthopedist and pediatrician on hospital staff.....	1
Physician of the crippled children's program on hospital staff.....	1

Physiotherapist on hospital staff.....	5
Physiotherapy equipment in hospital.....	3
Orthopedic nurses on hospital staff.....	3
Approval for orthopedic residency by American Medical Association.....	2

In some States more than one of these additional standards is required.

Comparing the standards adopted by State agencies with those recommended by the Children's Bureau Advisory Committee one is impressed with the need for the further strengthening of the State standards.

It might be contended that during the present national emergency hospital authorities will find it increasingly difficult to maintain certain standards of service because of shortages of personnel, equipment, and so forth. However, there will be relatively few hospitals that cannot provide certain essential facilities and services over and above those now required by the standards established by State agencies. In States where some hospitals have temporarily lost essential professional personnel it may be necessary, during the present emergency, for the State agency to limit the hospitals used under the State program to those where adequate facilities and services are still available.

Reference has been made to the standards that State agencies should expect in hospitals from which care is being purchased, e. g., adherence to standards established by the agency for the selection of such hospitals. On the other hand, the State agency should realize that if the hospitals meet the desirable standards which it sets up, there may be a resultant increase in the cost per patient-day and that unless provision is made to increase the per diem rate to be paid by the State agency the hospital will be in the position of having to provide services below cost, or services of substandard quality. State agencies must realize that improvements in hospital standards for the care of crippled children cannot be divorced from considerations pertaining to per diem rates to be paid for hospital care. The practice occasionally indulged in by State agencies of "shopping around" for bargains in hospital care scarcely tends to promote confidence among hospitals in the State agency or in its apparent interest in improving hospital standards.

One important reason why State officials have been reluctant to negotiate with hospital authorities in establishing per diem rates on the basis of cost per patient-day is the lack of uniformity in computing such costs. In some instances it has been impossible for the State agency to obtain information from hospitals regarding the basis used in computing the cost per patient-day. Where such informa-

tion has been obtained from several hospitals in the same community there is a lack of uniformity in the factors used in making such computations. It is hoped that accounting practices used by hospitals will soon become sufficiently standardized so that public agencies will be able to deal with them with a greater degree of confidence.

Another practice which has been the cause of much concern among public agencies has been the adoption of a per diem rate plus all the extra charges, which may result in unusually high costs. Attempts to establish rates on a flat-rate basis including all charges for laboratory work, X-ray, operating-room fees, anesthetics, anesthetist fees, and so forth, occasionally are vigorously opposed by hospital administrators even though the proposed flat rate be placed on a cost basis. There appears to be no reasonable justification for such opposition, and the adoption of a flat rate would greatly simplify the accounting procedures in both agencies and bring about improved relationships. The practice of exempting specific departments or services in the hospital is one of the obstacles in establishing a flat rate on a cost basis and is to be deprecated.

Although there has been unquestionably a gradual but steady improvement in hospital standards for the care of crippled children there is need for continued efforts on the part of both the public agencies and hospital authorities to bring about further progress in this direction. State agencies should periodically review the established hospital standards with a group such as a technical advisory committee composed of hospital administrators, orthopedic surgeons, pediatricians, nurses, physical-therapy technicians, medical-social workers, and other professional personnel engaged in services for crippled children in order to develop optimum standards rather than to be satisfied with minimum requirements. State agencies should also review present accounting practices with hospital authorities and urge the adoption of an acceptable uniform system of computing cost per patient-day and the use of a flat per diem rate including all ordinary charges for hospital care.

There is urgent need in all sections of the country for a better understanding between public agencies and hospital authorities of their mutual interests and of their responsibilities to the State and community which they serve. Through such an understanding there should emerge a greater unity of purpose, a growth in mutual respect and confidence, and improved quality of services for crippled children.

BOOK NOTES

Nutrition

INFANT NUTRITION: a textbook of infant feeding for students and practitioners of medicine, by Williams McKim Marriott, M. D., and P. C. Jeans, M. D. C. V. Mosby Co., St. Louis. 1941. 475 pp. \$5.50.

This book on nutrition of infants in health and disease, prepared by Dr. Marriott in 1935, has been thoroughly revised and brought up to date by Dr. Jeans. Some chapters have been expanded, including those on growth and development and on water and mineral metabolism and an especially useful discussion of the addition of solid foods under the heading, *The Diet of the Normal Infant*. A notable achievement is the up-to-date revision of the material on the vitamins and vitamin-deficiency diseases. The chapters on acid milk and on special and proprietary foods have been condensed, the latter much improved by the omission of trade names (the reader is referred to the American Medical Association's publication, *Accepted Foods and Their Nutritional Significance*). The chapters on vomiting, diarrhea, and prematurity are long and complete.

The value of the book is increased by an excellent index and the liberal use of subheadings. There is no bibliography.

M. D.

NUTRITION STUDY IN PREGNANCY, by Philip F. Williams and Florence G. Fraulin. *American Journal of Obstetrics and Gynecology*, Vol. 43, No. 1 (January 1942), pp. 1-20.

The diets of 514 pregnant Philadelphia women who kept food records for a week were analyzed as to dietary adequacy in comparison with the allowances for specific nutrients recommended by the National Research Council. The group included white and Negro women and both clinic and private patients. Almost 30 percent of the white women and more than 80 percent of the Negro women came from families with per capita incomes of less than \$4.89 a week.

The diets of only 10 of the women could be considered good on the basis of the recommendations of the National Research Council; 269 were classed as fair; and 295, as poor. Intakes of nutrients were furthest below the recommended allowances with respect to calcium, vitamin A, vitamin B₁, ascorbic acid, and riboflavin.

Of the women studied approximately half had an apparently normal reproductive experience; the average diet of this group did not differ significantly from that of the group as a whole. The diet of the women who suffered from one or more complications was studied with particular reference to specific nutrients that other investigators had considered might be a factor, but no significant relationship was apparent in the comparatively small series studied. The need for long-term studies with adequate controls is stressed.

NUTRITION IN RELATION TO PREGNANCY AND LACTATION, by J. Ernestine Becker, Hugh J. Bickertstaff, and Nicholson J. Eastman. *American Journal of Public Health*, Vol. 31, No. 12 (December 1941), pp. 1263-1270.

Present-day knowledge of nutritive needs during pregnancy and lactation is reviewed by two members of the faculty of the School of Hygiene and Public Health and a professor of obstetrics in the Medical School of Johns Hopkins University. Clinical and experimental evidence is cited as to the importance of an adequate diet for all women during the maternity

cycle. The taking of a detailed food history several times during pregnancy as a basis for dietary recommendations seems as much a part of the management of pregnancy as the physical examination and the medical history.

THE ART AND SCIENCE OF NUTRITION, by Estelle E. Hawley and Grace Carden. C. V. Mosby Co., St. Louis, 1941. 619 pp. \$3.50.

What the nurse in private duty needs to know about foods and nutrition is presented in four main sections: (1) Normal nutrition; (2) food requirements under special conditions; (3) diet therapy; and (4) the choice, preparation, and serving of foods. The subject matter and the arrangement of the book have been planned to conform to the requirements of the Committee on Education of the National League of Nursing Education. There are many black and white illustrations and several colored plates. Apparently the book went to press before the recommended dietary allowances of the National Research Council were published.

THE PREVALENCE OF MALNUTRITION, by Norman Jolliffe, James S. Mc Lester, and H. C. Sherman. *Journal of American Medical Association*, Vol. 118, No. 12 (March 21, 1942), pp. 944-950.

Acting as a subcommittee of the Food and Nutrition Board of the National Research Council, these three writers have attempted to reconcile the widely varying estimates of the prevalence of malnutrition in the United States. They review the evidence from dietary surveys, mortality from dietary deficiencies, hospital admissions and records, and medical assessment of the nutritional status of population groups. They conclude that incidence of "strikingly obvious" types of malnutrition is very low but that types apparent only to the physician who makes a very careful examination or uses special diagnostic techniques are common. In their opinion there is room for widespread improvement in the nutritional status of the people of this country.

MODERN BREAD FROM THE VIEWPOINT OF NUTRITION, by Henry C. Sherman and Constance S. Pearson. Macmillan Co., New York, 1942. 118 pp. \$1.75.

Recent technological developments in milling and bread-making are making available commercial breads of high nutritive value. Among the chief methods for the nutritional improvement of bread are: (1) The milling of wheat so as to retain most of the minerals and vitamins of the whole grain while discarding the coarse bran; (2) use of dried skim milk in maximum proportions; (3) the use of vitamin-rich-yeast; (4) retention of the wheat germ or its addition to the dough in making bread from white flour; (5) the addition of vitamins and mineral salts in pure form or as artificial concentrates. Breads that have been improved nutritionally by one of these methods or a combination of them may well occupy a prominent place in the diet for physiological as well as economic reasons.

MANUAL FOR MANAGERS OF RURAL AND OTHER SMALL SCHOOL LUNCHROOMS. Ohio Dietetic Association, 1101 Huron Road, Cleveland, 1942. 226 pp. \$1.50.

In preparing this manual the Community Education Section of the Ohio Dietetic Association had the cooperation of six agencies and organizations interested in lunches for children in rural or other small schools.

The school lunchroom is considered a facility for health education as well as for health service.

The first third of the book deals with important matters of organization and operation, such as equipment and arrangement, standards for food and personnel, purchasing and cost accounting. There follows a section of recipes for low-cost dishes of high nutritive value in proportions to serve 10, 25, or 50 children.

THE INFLUENCE OF NUTRITIONAL SUPERVISION ON DENTAL CARIES, by Percy R. Howe, Ruth L. White, and Mark D. Elliott. *Journal of American Dental Association*, vol. 29 (January 1942), pp. 38-43.

The incidence of new cavities in the teeth of a group of 189 children who were receiving guidance through the nutrition clinic of the Forsyth Dental Infirmary was compared with the incidence in a control group of infirmary patients who had received no nutritional supervision. Over a period of slightly more than 3 years, the average number of new cavities per child per year was 56 percent lower in the group of supervised children than in the control group. In the judgment of the authors the findings indicate that progress in dental caries can be reduced substantially by an intensive educational program in nutrition.

MEDICAL EVALUATION OF NUTRITIONAL STATUS, Part 7, Diets of High School Students of Low-Income Families in New York City, by Dorothy G. Wiehl, Part 8, The School Lunch as a Method for Improving Diets of High School Students, by Emily K. Stannum and Dorothy G. Wiehl. *Milbank Memorial Fund Quarterly*, Vol. 20, No. 1 (January 1942), pp. 61-96.

Diet histories of more than 2,000 pupils of a high school in the lower East Side district of New York City were collected by interviews in their homes and at the clinic operated as part of a cooperative project in the evaluation of nutritional status. As measured by the dietary allowances recommended by the committee on food and nutrition of the National Research Council, the diets of a large percentage of these pupils were deficient in one or more nutrients. In general the diets were most nearly adequate in protein content and least adequate in vitamin A, calcium, and ascorbic acid. The high proportion of diets furnishing inadequate amounts of vitamin A and ascorbic acid substantiated evidences of deficiencies of these nutrients in the medical findings.

As most of the high-school students ate their noon meal at school, it seemed that one of the objects of the school cafeteria service should be to furnish an appreciable share of the nutrients needed daily, especially of those in which the home diet was low. An analysis was made of the food values of the lunches eaten at school, whether these lunches were brought from home, bought at school, or furnished free by the school. Except for the children who received the free lunch, which included milk and consequently contributed important amounts of calcium and riboflavin, the pupils did not eat lunches that tended to make up the deficiencies in their home diet.

Suggested means for improving the nutritive value of the lunches include: (1) increase in the quantity of filling in sandwiches; (2) more liberal portions of inexpensive main dishes; (3) wider use of vegetables rich in vitamin A; (4) replacement of bottled drinks

with fruit juices to bring up intake of ascorbic acid; (5) guidance in choice of foods. The economic difficulties in carrying out some of these improvements are recognized.

M. M. H.

Child Health

SCHIZOPHRENIA IN CHILDHOOD, by Charles Bradley, M. D. Macmillan Co., New York, 1941, 152 pp. \$2.50.

Schizophrenia, although infrequent in childhood, does occur often enough for a considerable volume of literature to have been built up. Dr. Bradley has made a survey of the literature on the subject in many languages. His book opens with a discussion of what is meant by schizophrenia with illustrations of how the disorder may appear in children. He then passes on to a survey of the literature, interspersing it with observations from his own practice. The book closes with the author's concept of the nature of schizophrenia in childhood.

D. V. W.

CHILDREN HAVE THEIR REASONS, by Ruth Wendell Washburn, Ph. D. D. Appleton-Century Co., New York, 1942, 257 pp. \$2.

Dr. Washburn has reiterated the problems of the modern parent and the answers of the psychologist to these problems. Being herself an experienced psychologist, Dr. Washburn brings to bear an insight into the reactions of children and their parents—an insight which points the way toward solutions of the problems raised. She has no general formula to advance—unless it be that she urges upon parents that they attempt to put themselves in the shoes of their children and try to understand the children's reasons for doing as they do.

Much emphasis is put in this volume on the avoidance of behavior problems in children by means of an understanding on the part of the parents of the pitfalls to be avoided. Dr. Washburn advocates that parents consult a psychologist as a matter of routine much as they would consult a pediatrician, even though their child is healthy.

D. V. W.

ELECTROCARDIOGRAPHY, by Louis N. Katz, M. D. Lea & Febiger, Philadelphia, 1941, 580 pp. \$10.

EXERCISES IN ELECTROCARDIOGRAPHIC INTERPRETATION, by Louis N. Katz, M. D. Lea & Febiger, Philadelphia, 1941, 222 pp. \$5.

Dr. Katz believes that the electrocardiogram "must be correlated with the rest of the patient's story and findings, and this correlation must be made by the clinician who has seen the patient." His work is designed to equip the physician to interpret his own records. It gives a sound general understanding of electrocardiography, both theoretical and practical, with many illustrations. The discussions of the influence of age on the electrocardiogram and the changes brought about by rheumatic fever and the other acute infections of childhood are of particular interest to the pediatrician.

• **CHILD WELFARE** •

• **SOCIAL SERVICES** •

• **CHILD GUIDANCE** •

BOOK NOTES

Education for Home and Family Living

For many years "worthy home membership" has been included among the generally accepted objectives of education. But how to achieve this purpose, what to do in schools to attain this goal has not been so generally recognized and understood. Several recent studies of family-life education, prepared by individual deliberative bodies, were published within a few months of each other. Although some of the activities discussed and some of the issues raised may be of controversial nature, the volumes present much of current interest and direct timely attention to the need as well as the possibilities of developing programs and procedures designed to meet the objective of "worthy home membership." A brief review of each book follows:

YOUTH, FAMILY, AND EDUCATION, by Joseph K. Folsom. American Council on Education. Washington, 1941. 299 pp. \$1.75. The author describes changing objectives in education from a sociological point of view, portrays modern problems in family living, traces the development of the movement for education in family living, and reports on present-day activities together with the problems involved in these activities. In the section dealing with current activities and problems in education for family living he presents information on the schools at all levels, outside agencies, family case work and counseling, and various community, State, and National organizations. The last chapter is "an effort at tentative evaluation." The appendix lists agencies that promote education for family living and research in allied fields. A bibliography is included.

EDUCATION FOR FAMILY LIFE. Nineteenth Yearbook, American Association of School Administrators. National Education Association of the United States. Washington, 1941. 368 pp. \$2. "This yearbook seeks to give impetus to a movement already begun, to develop a more general consciousness of the importance of training for family life as a responsibility of public education, and to provide a broad understanding of the problems involved which will serve as a basis for developing a comprehensive and sound program in the public schools." The worth of the family in terms of the needs of society, the forces destructive to home life, the changes that have taken place in family life in recent years, and the need for specific education in family living, and

concrete suggestions for a program in family living are among the subjects presented. In general, emphasis is on principles and problems rather than on procedures. There is an appendix listing organizations with materials and services of use in education for family life, and a bibliography.

FAMILY LIVING AND OUR SCHOOLS; suggestions for instructional programs. Joint Committee on Curriculum Aspects of Education for Home and Family Living of the Home Economics Department of the National Education Association and the Society for Curriculum Study. D. Appleton-Century Co. New York, 1941. 468 pp. \$2.50.

An intensive study of school programs and practices conducted by the committee representing the Society for Curriculum Study and the Department of Home Economics of the National Education Association with the assistance of the United States Office of Education forms the basis for this book, which gives a picture of what the schools are now doing to help individuals of all ages to become more effective members of homes and families. Bess Goodykoontz and Benah I. Coon were co-chairmen of this committee. Although the emphasis is on programs and practices that are proving successful, many suggestions are given for enriching programs and improving methods. In the appendix several charts of developmental sequence in learning are presented for use with children at various age levels, and ways are outlined in which family life and the school can facilitate this learning. This volume and the yearbook of the American Association of School Administrators were planned to complement each other.

* * *

THE EDUCATION OF FREE MEN IN AMERICAN DEMOCRACY. Educational Policies Commission, National Education Association of the United States and American Association of School Administrators. Washington, 1941. 115 pp. 50 cents.

"If the people of the United States are to bear the heavy responsibility which history is apparently placing on their shoulders, they must proceed without delay to the development of a comprehensive program of defense and advance.

"The first necessity in the development of such a program is the achievement of a clear understanding of the nature of democracy and a clear perception of the values at stake. Only when this has been done can free men be expected to throw their energies without reserve into the struggle. Only when this has been done can education for democracy, as a part of an inclusive program of action, take on meaning, pattern, and direction."

The initial chapters are devoted to discussion of The Tides of Freedom and Despotism, Totalitarian

Strategy and Dynamic Democracy, and Democracy as a Great Social Faith. It is pointed out that American democracy, "if it is to be an effective force in the gigantic conflict between the two opposing philosophies of life involved in the present crisis," must meet, in addition to the need for armed defense, such objectives as a greater measure of equality and security in economic condition and opportunity among the people, sharper attention to the general welfare and the long-time interests of society, and a substantial measure of popular agreement on essential values, principles, and procedures.

Later chapters are concerned with the importance of the loyalties, knowledge, and discipline of a free people and with the place of education in the development of such attributes. In the chapter on *The Loyalties of Free Men* it is observed that "the defense of American democracy against the totalitarian threat requires the development in the young of clearer, stronger, and more positive loyalties to the values which free men cherish. The development of these loyalties is a major, a crucial responsibility of the public school. Indeed, an education that fails to deal successfully with this problem can in no sense be regarded as democratic either in purpose or in result."

The final chapter is devoted to a consideration of where the control of democratic education should be lodged and outlines the responsibilities and obligations of government, of the teachers, and of the people.

D. H. F.

Concerning Children in Wartime

Defense of Children The Children's Bureau *Defense of Children* Series consists of 11 leaflets under the general heading, "Children Bear the Promise of a Better World." Of uniform design, each of these illustrated leaflets has its own distinctive color scheme and deals with some one aspect of child life that especially concerns the Children's Bureau.

The titles of the leaflets are as follows:

1. What Are We Doing To Defend Them?
2. Are We Safeguarding Those Whose Mothers Work?
3. Are They Getting the Right Start in Life?
4. Have They the Protection of Proper Food?
5. Are We Defending Their Right to Health?
6. Their Defense Is the Security They Find at Home.
7. Their Education Is Democracy's Strength.
8. Through Play They Learn What Freedom Means.
9. Our Nation Does Not Need Their Toil.
10. Are We Helping Those With Special Needs?
11. Protect Them From Harmful Community Influences.

Single copies can be obtained free from the Children's Bureau. They can be purchased in quantity from the Superintendent of Documents at \$3 per 100.

Children in Wartime To Parents in Wartime is the title of the first pamphlet in a new series on Children in Wartime that is being issued by the Children's Bureau. To Parents in Wartime

(Bureau Publication 282) is a 20-page pamphlet containing suggestions to parents for maintaining family morale by preparing themselves to face whatever may come and by helping their children to continue living their everyday lives with as little change as possible.

A Children's Charter in Wartime, adopted by the Children's Bureau Commission on Children in Wartime, March 16-18, 1942, has been published in folder form as the second pamphlet in this series. The Charter was published in *The Child* for April 1942.

Public Health Service Until the Doctor Comes is the title of a booklet issued by the United States Public Health Service, Federal Security Agency (Miscellaneous Publication No. 21, Washington, 1941. 60 pp.). The text on each topic is kept to a minimum and is supplemented with diagrams. The arrangement is such as to make it usable in a poor light or by a person who is excited or who is unaccustomed to reading directions. The booklet was prepared by James A. Dolce, M. D., of the United States Public Health Service. It is not intended to serve as a complete first-aid manual or to encourage self-treatment. It contains simple emergency measures which may add to the comfort of an injured person, prevent the development of serious complications, and perhaps contribute to the saving of life.

Child Study Association of America Questions of parents seeking to prevent the war from disrupting their children's sense of security are answered by the staff of the Child Study Association of America in a pamphlet entitled "Children in Wartime" (Child Study Association of America, 221 West 57th St., New York, 1942, 15 pp.).

Child Guidance

Camp Fire Girls A syllabus for an Introductory Course in Baby Care (1942, 50 pp. Mimeographed. 20 cents) is now available in revised form from Camp Fire Girls National Headquarters (88 Lexington Ave., New York). Ruth Stephens Lyden, who prepared the revised course, is the mother of a 2-year-old child and was formerly a member of the Camp Fire Girls. The eight lessons deal with the baby's family surroundings, his wardrobe, his bath, his diet, food for the family, baby's temperament and health, a review quiz, and a supplementary lesson on sex education. The bibliography lists books, pamphlets, motion pictures, and other supplementary teaching material. A simple play is given which shows how a group of Camp Fire Girls put the baby-care course into practice.

American Medical Association A group of pamphlets on sex education issued by the American Medical Association (535 North Dearborn St., Chicago) as reprints from *Hygienica* include the following titles, priced at 15 cents each:

- Sex Education for the Preschool Child, by Harold E. Jones and Katherine Read. 1941. 12 pp.
- Sex Education for the Ten-Year-Old, by M. Marjorie Bolles. 1941. 12 pp.
- Sex Education for the Adolescent, by George W. Corner and Carney Landis. 1941. 18 pp.

Public Welfare

DIRECT AND WORK RELIEF AND FEDERAL WORK PROGRAMS IN ALLEGHENY COUNTY, 1920-1941, by Ralph Carr Fletcher, Katherine A. Biehl, and Joseph Zarafsky. Social Research Monograph No. 5, Bureau of Social Research, Federation of Social Agencies of Pittsburgh and Allegheny County, Pittsburgh, Pa. 53 pp. 75 cents.

Expenditures for outdoor relief and work programs in Allegheny County totalled almost \$300,000,000 for the period 1920-41. The summary statement and analysis of these expenditures show the pattern of assistance resulting from an urban community from the operation of various Federal and State local relief programs. "Much of the material used in this monograph was secured from the regular reports submitted by the agency in cooperation with the registration project of the United States Children's Bureau." The recent history of relief in Allegheny County is seen as a period of increasing specialization of individual program functions and at the same time a broadening of the scope of total relief activities.

The several relief and work programs are described and expenditure data are presented for each. Case-load figures are given for most of the programs. The volume of noninstitutional medical care is separately analyzed through expenditures of the various agencies extending such care. The continuing provision of public noninstitutional medical care and the increasingly large part played in this program by public agencies is taken to indicate an acceptance of the responsibility by public-assistance agencies for this type of care.

E. E. S.

THE STATE BECOMES A SOCIAL WORKER; an administrative interpretation, by Arthur W. James. Garrett & Massie, Richmond, 1942. 368 pp. \$3.

The author, who was in charge of the educational program of the Virginia Department of Public Welfare from 1922 to 1938, presents this record of the development of the department and its program during that period through contemporaneous material taken from public addresses, bulletins, reports, correspondence, memoranda, and periodicals.

Part 1 deals with public-welfare organization and part 2, with public-welfare programs, including social security.

In a volume published in 1940, Virginia's Social Awakening, the author traced the work of the Virginia Board of Charities and Corrections up to 1922, when it was reorganized as the Board of Public Welfare.

Juvenile Delinquency

JUVENILE OFFENCES. Home Office Circular 807624. H. M. Stationery Office, London, 1941. 15 pp. Price, 3d. net.

For the first 12 months of the war the number of minors found guilty of indictable offenses in England, as reported in this memorandum, showed an increase of 41 percent for children under 14 years, 22 percent for the 14- to 17-year group, and 5 percent for the age group 17 and under 21 years.

For the younger children the increase in delinquency was attributed primarily to the breaking up of home life because of the absence of the fathers on military service, the employment of the mothers, and the evacuation of the children. For those of school age the interruption of school life arising from evacuation and the closing of the schools in the early stages of the war is given as a major cause, explaining the large increase in offenses early in 1940 and the falling off later in the year as schools began to open. For boys over school age it was thought that lack of organized recreation was an important cause, especially in the absence of the father from the home; and that the payment of wages as high as 3 to 5 pounds a week to boys working in defense industries brought them temptations which they were unprepared to resist. The "effect of the excitement and unsettlement of war on adolescent boys" and the opportunities for easy looting, especially in the blackout, are also mentioned.

The memorandum places emphasis on preventive measures. For school children these include the restoration of educational facilities, a stricter enforcement of school attendance, and supervised recreation. "There is evidence of young children getting out of hand through lack of domestic care before and after school. A number of local education authorities, especially in reception areas, have already recognized this need and have organized centers, usually in school buildings, where boys and girls can play games or carry on hobbies. A more general provision of these facilities is greatly to be desired."

Local education authorities are warned that there may be a tendency for employers to resort to child employment, and that the provisions of the Children and Young Persons Act, 1933, must be complied with. Light agricultural work during school holidays may be allowed for children over 12 years under local by-laws, if the restrictions on hours of work and kind of work are observed.

The social welfare of young people who have left school has been made the responsibility of the Board of Education, which has set up a National Youth Committee to advise on all aspects of juvenile welfare. Local youth committees are now in active operation in nearly all the higher education areas, and many new centers, clubs, and units have been started. "One of the best means of checking delinquency in wartime, as in peace, is to provide more, and more varied, social and recreative facilities to meet the needs and tastes of all sections of the youthful community * * * and to challenge youthful exuberance to interest itself in useful service."

Recommendations are made as to the treatment of juvenile offenders: Careful consideration should be given to the reports of the local education authority and the probation officer. Parents should be made to realize their responsibility. Skilled advice should be sought on the treatment of difficult problems of behavior, it is emphasized; child-guidance clinics have been established by local education authorities in many towns and these have available the services of a psychiatrist. Use of the probation system should be considered in every case, and detention in "remand homes" or "approved schools" should be resorted to only in the case of offenders "who are not likely to respond to probation."

• **CHILD LABOR** •

• **YOUTH EMPLOYMENT** •

• **VOCATIONAL OPPORTUNITIES** •

Exemption Granted Under the Walsh-Healey Act

At the request of the Secretary of War, an exemption to the 18-year minimum age established by the Walsh-Healey Act for the employment of girls on Government contracts was granted by the Secretary of Labor, under the authority of the act, on April 21, 1942. Under the exemption, employment of girls is permitted in enumerated industries under certain conditions at 16 years of age, the same age which the act sets for the employment of boys.

Girls 16 and 17 years of age are permitted to be employed only under specified conditions regulating maximum hours, night work, and wage rates, and protecting them from employment in hazardous occupations. Each contractor must keep on file for each girl employed under 18 years of age a certificate of age showing that she is at least 16.

Under the exemption, girls 16 and 17 years of age may not work more than 8 hours a day or contrary to State laws governing hours of work. Night work is prohibited between 10 p. m. and 6 a. m. At least a 30-minute lunch period must be provided, and the wages paid must be not less than the minimum hourly rate set by the Fair Labor Standards Act or the Walsh-

Healey Act. Furthermore, these girls may not be employed in any occupation declared hazardous under the Fair Labor Standards Act. Thus, although the arms and ammunitions industry is listed among those granted the exemption, this does not remove the coverage of Hazardous Occupations Order No. 1, issued under the Fair Labor Standards Act, prohibiting minors under 18 from working in any occupation "in or about plants manufacturing explosives or articles containing explosive components."

The industries in which girls of 16 and 17 years may be employed under the exemption are:

- Food processing.
- Leather products.
- Boots and shoes.
- Rubber products.
- Photographic equipment and supplies.
- Chemical, drug and allied products.
- Surgical and scientific instruments.
- Optical instruments.
- Arms and ammunition.
- Electrical manufacturing.
- Plastic products.
- Safety appliances.
- Machinery and allied products.
- Converted paper products.
- Fabrication of metal products.

• EVENTS OF CURRENT INTEREST •

ADDITIONAL SUMMER COURSES

University of Iowa Courses in child development and parent education are offered by the University of Iowa, June 8 to July 31. The Iowa Child Welfare Research Station and cooperating departments will present courses for teachers, graduate students, social workers, study group leaders, and parents.

Date of Chicago Conference Changed A notice from the National Education Association states that the Conference on Human Development and Education at the University of Chicago will be held August 10 through August 21. The dates previously announced were July 27 through August 7. This conference is sponsored jointly by the University of Chicago, the Commission on Teacher Education, and the Department of Supervisors and Directors of Instruction of the N. E. A.

CONFERENCE CALENDAR

June 28-July 2—National Education Association. Eightieth annual convention, Denver.

June 28-July 3—American Physiotherapy Association. Twenty-first annual conference, Williams Bay, Wis.

Sept. 28-Oct. 2—National Recreation Association. Cincinnati.

Oct. 5-9—National Safety Council. Chicago.

Oct. 12-16—American Hospital Association. St. Louis, Mo.

Oct. 27-30—American Public Health Association. Seventy-first annual meeting, St. Louis, Mo.

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF



THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to Miriam Keeler, editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at \$1 a year; foreign postage, \$0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

Social Statistics

MARCH—JUNE 1942

Supplement

Nos. 3 and 4 to

THE CHILD, Vol. 6



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S O C I A L S T A T I S T I C S

Nos. 3 and 4 -- March-June 1942

Prepared by

Division of Statistical Research,

Children's Bureau

Supplement to THE CHILD, Volume 6

INTRODUCTION

Reporting of statistics of social and health services provided by 42 urban communities to the project for the registration of social statistics of the Children's Bureau was better during 1940 and 1941 than at any previous time. The improvement has produced more complete and accurate central records of services provided in the registration areas and, therefore, provides more nearly comparable figures for the study of changes in the community-welfare picture which occurred when the country was experiencing unprecedented expansion in defense and war activities.

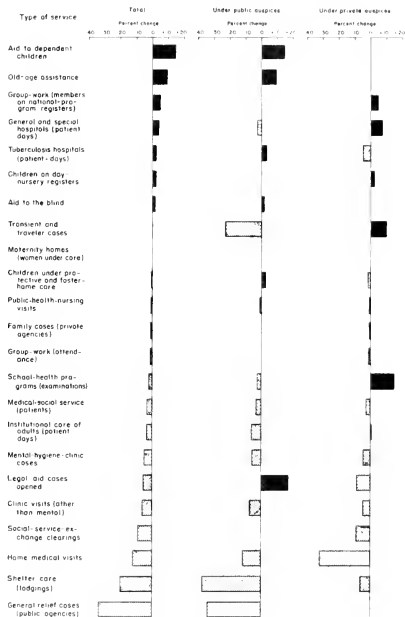
This summary of reports for 1941 in comparison with reports for 1940 also provides a bench mark for the further measurement of the volume of social and health services in a substantial portion of the urban communities of the United States. 1/ Determination of the size of social and health programs in the period immediately before the entrance of the United States into the war will facilitate appraisals of the effect of the war on this important part of the Nation's social structure.

Immediately of interest are the quantitative changes taking place in the programs of social and health services during an upward swing in the business cycle. War production went into high gear in 1941. Employment soared in most metropolitan areas. The average monthly index of employment in manufacturing industries of the Bureau of Labor Statistics rose to new highs in 1940 in all but one of the registration areas (Duluth) represented in their figures. 2/ The rise continued into 1941 in all but one area (Grand Rapids). Comparison of employment indexes for December 1941 with those for the corresponding month of 1940 show decreases only in the Detroit and Grand Rapids areas (4.3 percent and 13.5 percent, respectively), and increases in all other registration areas included, ranging from 2.8 percent (Richmond) to 66.6 percent (Wichita). 3/

Against this picture of generally improved employment in the registration areas, this article presents a comparison of selected social service

and health statistics to indicate the coincidental changes in social and health services, in terms of average monthly figures reported for 1941, and the percentage of change from 1940. The detailed figures are presented in appendix tables 1 and 2. The percentage changes are presented graphically in figure 1. Because the plotting in this figure is on a percentage basis the direction of change in total services is influenced by the relative pro-

FIG. 1—PERCENTAGE CHANGE FROM 1940 IN AVERAGE MONTHLY FIGURES FOR SELECTED TYPES OF SOCIAL AND HEALTH SERVICE IN 42 URBAN AREAS, 1941



portion of the total services which were provided by public and by private agencies.

The number of areas in the registration project during 1940 and 1941, the number of agencies

1/ The combined population of the 42 reporting areas in 1940 represented about 50 percent of the total population of the United States in urban areas of 100,000 or more inhabitants.

2/ U. S. Department of Labor, Bureau of Labor Statistics: Index of Employment in Manufacturing Industries, by Metropolitan Area. Press release, October 1941.

3/ U. S. Department of Labor, Bureau of Labor Statistics: Index of Employment in Manufacturing Industries, by Metropolitan Area. December 1941.

Table 1.--Number and combined population of reporting areas and agencies included, by selected types of service, 1940 and 1941

Type of service	Number of areas				Number of agencies reporting a/	Combined population of reporting areas, 1940 census
	Reporting			Not reporting		
	Total	Service	No organized service			
Family:						
Family welfare and relief, private.....	42	42	.....	.....	305	26,848,154
Family welfare and relief, public.....	42	42	.....	.....	103	26,954,006
Aid to dependent children.....	41	41	.....	1	53	26,671,340
Old-age assistance.....	41	41	.....	1	49	26,671,340
Aid to the blind.....	40	39	1	2	47	26,495,458
Service and relief to transients and travelers.....	40	35	5	2	45	24,959,499
Shelter care for transient and homeless.....	37	36	1	5	135	24,940,416
Legal aid.....	39	28	11	3	30	25,032,636
Institutions for aged.....	25	24	1	17	189	16,256,545
Child welfare:						
Protective and foster care.....	38	38	.....	4	591	25,355,861
Day-nursery care.....	40	34	6	2	159	25,858,650
Maternity-home care.....	39	35	4	3	80	25,747,307
Health:						
Hospital in-patient.....	30	30	.....	12	435	19,612,453
Clinic, other than mental-hygiene.....	38	38	.....	4	437	25,103,970
Mental-hygiene clinic.....	36	29	7	6	47	19,449,064
Medical service in patient's home and in doctor's office.....	25	24	1	17	55	16,985,935
Medical-social service.....	34	25	9	8	109	19,391,337
Public-health nursing.....	35	35	.....	7	195	19,810,274
School hygiene.....	35	33	2	7	83	19,810,274
Group work:						
Service of group-work agencies.....	30	30	.....	12	304	14,934,575
Local groups organized under national programs.....	36	36	.....	6	105	21,106,198
Social-service exchange.....	41	41	.....	1	42	26,077,338

a/ Includes duplication among types of service in instances where a single agency in an area provides a separately organized service in two or more specified fields.

included in the classification of fields of service reported, and the population covered by each type of service are shown in table 1. A description of the registration areas is given in appendix table 3. The differences noted there in the geographical boundaries of the areas should be kept in mind as a source of incomparability of areas. 4/

Coverage of the 1940 and 1941 statistics was well over 90 percent in most of the fields of ser-

vice in nearly all of the areas. 5/ The statistics for all types of service for which nonresidents are not considered a responsibility of the local community, except those for hospital in-patient service, have been adjusted to include only service given to persons resident in the area, with minor exceptions in certain areas. The statistics do not represent all the work of the reporting agencies but only services provided in connection with the chief functions of the agency.

Because there is considerable variation in the relative importance of each of the types of

4/ The territory included in each reporting area was determined locally and coincides as a general rule with the planning area of the council of social agencies or the fund-raising area of the community chest.

5/ An area is not included in a field if it cannot give assurance that it can report promptly each month at least 80 percent of the total volume of service in the specified field.

service selected for reporting, it would be desirable to express the figures in terms of ratios. However, the service figures themselves do not permit the use of this technique because there is no denominator which is common to all types. In some fields they represent the number of cases served and in others the number of services provided to individuals. Financial data, although presenting certain limitations with respect to an absolute measure, have the merits of the dollar as a common denominator and can be expressed as parts of the whole.

Table 2.—Percentage distribution of net expenditures for selected fields of social and health service in 34 urban areas, 1940 a/

Fields of service	Percent of total
Total, 21 fields covered by service reports.....	100.0
Family.....	70.1
Family welfare and relief, private agencies.....	2.4
Family welfare and relief, public agencies.....	30.8
Aid to dependent children.....	6.1
Old-age assistance.....	25.6
Aid to the blind.....	1.3
Service and relief to transients and travelers.....	0.2
Shelter care for transients and homeless.....	0.7
Legal aid.....	0.1
Institutions for aged.....	2.9
Child welfare.....	6.0
Protective and foster care.....	5.6
Day-nursery care.....	0.2
Maternity-home care.....	0.2
Health.....	20.8
Hospital in-patient.....	14.7
Clinic, other than mental-hygiene.....	2.8
Mental-hygiene clinic.....	0.2
Medical service in patient's home and in doctor's office.....	0.6
Medical-social service.....	b/
Public-health nursing.....	2.0
School hygiene other than nursing.....	0.5
Group work.....	3.1
Service of local group-work agencies....	2.6
Local groups organized under national programs.....	0.5

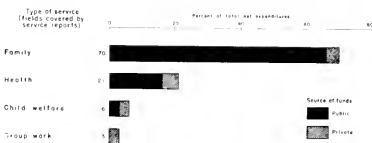
a/ The Community Welfare Picture in 34 Urban Areas, 1940.

b/ Included in expenditures for hospitals and clinics.

Twenty-one types of service have been selected for comparison of expenditures reported for the year 1940 in 34 urban areas. 6/ They represent selected services provided to individuals in the fields of family service, child-welfare service, health service, and group-work service. 7/ The relative importance of the 21 selected programs in 1940 in the 34 urban areas combined is shown in table 2.

A percentage distribution of the 1940 net expenditures by major fields of service is given in figure 2. This shows that family services accounted for 70 percent of the total expenditures reported for the 21 types of service; health services, 21 percent; child-welfare services, 6 percent; and group-work services, 3 percent.

FIG 2.—PERCENTAGE DISTRIBUTION OF NET EXPENDITURES FOR SELECTED FIELDS OF SOCIAL AND HEALTH SERVICE IN 34 URBAN AREAS, 1940



CHANGES, 1940 TO 1941, IN THE VOLUME OF SOCIAL AND HEALTH SERVICES FOR 42 URBAN AREAS COMBINED

The general experience of 42 urban areas in 1941 shows decreases from 1940 in most of the selected social and health services. The sharpest decreases were reported in family service and in health service. The decreases were generally more pronounced in services under public auspices than in those under private auspices. Figure 1 indicates these changes.

The greatest change was reported in the broad field of family service and reflected the most extreme variations in total services among individual programs. Those programs in which the need for

6/ U. S. Department of Labor, Children's Bureau: The Community Welfare Picture in 34 Urban Areas, 1940. Washington, June 1941.

7/ Among other important types of social and health services provided in the urban areas to individuals but not included by the current service reports of the registration of social statistics are: Services for delinquent adults, services provided chiefly by juvenile courts for children with conduct problems, institutional care of delinquent children, public recreation services, summer-camp programs, fresh-air camps, mental hospital in-patient services, and certain public-health department activities. Services to agencies rather than to individuals, which are omitted from this expenditure analysis, include services of central planning and financing organizations and social-service exchanges.

service is directly related to fluctuations in employment—public general relief and shelter care—showed the most drastic curtailment in 1941. Case loads increased in the programs for special types of public assistance—old-age assistance, aid to dependent children, and aid to the blind—which may not be so immediately affected by changes in the general level of employment.

Four of the nine types of service in the family field are provided by both public and private agencies. On the whole, the services provided by public agencies showed the most pronounced changes from 1940. In some programs, notably legal aid and service and relief to transients and travelers, both public and private agencies provide service. In the legal-aid field public service increased while private programs decreased in size. In the field of relief to transients and travelers, given largely by travelers-aid societies affiliated with the United Service Organizations, private agencies showed a 10-percent increase.

Health service showed changes within a narrower range in the total services reported by the combined 42 areas than did family service. Six of the 7 types of service within this broad field showed decreases from 1940. The sharpest decrease was reported in medical service to patients in their homes, especially in services provided by private agencies. The sharpest increase was in admissions to tuberculosis hospitals.

Differences of some magnitude were noted in the direction of change for in-patient services of public and private hospitals. Admissions to and total patient-days in public general and special hospitals declined whereas relatively large increases in the same statistics were shown for private general and special hospitals. On the other hand, the reports of public tuberculosis hospitals showed increases in total and free patient-days and the figures of private tuberculosis hospitals, decreases.

The decrease in free patient-days in private general and special hospitals contrasts with an increase in the total patient-days care given by these hospitals. This may be due to a greater ability to pay for service because of improved local economic conditions and the rapid expansion of hospital service plans providing for the prepayment of hospital services.

There were relatively small changes in the volume of child-welfare service. The range of change was between a decrease of 2.9 percent (children in institutions) and an increase of 2.5 percent (children in day nurseries). Maternity-home care showed no change whatever. A small increase was reported in the number of children in day nurseries.

The chief contrast between public and private service statistics in the child-welfare field was reflected in the figures reported for the total number of dependent and neglected children under care in foster homes, which showed almost no total change but showed an increase in public-agency service and a decrease in private-agency service in 1941.

Reports from the several types of private organizations in the group-work field reflect little expansion in leisure-time activities. A slight decrease was noted in attendance at selected group-work activities, whereas the number of members on the registers of national-program groups showed an increase.

A review of the 1941 statistics indicates the influence of increased employment and improved economic conditions on the volume of the selected social and health services. The development of a general pattern of change attributable to war activity among the areas reporting the selected social and health services is not yet in evidence. The development of war activities did not, of course, affect all communities to the same extent in 1941. The unevenness of this development may be one of the local influences reflected in the wide variations among reporting areas in the direction and amplitude of changes which characterize the statistics.

The response of social agencies to the war situation may not be apparent in the statistics reported for 1941 because of the lag between the appearance of a need for service and its provision by a social agency. Relief was not provided on a large scale by many communities until the second or third year, or later, of the depression that began in 1929. It took time to develop reporting procedures covering emergency depression activities. It may take as long or longer for communities to recognize the more complex problems arising from the war situation, to launch needed programs, for such programs to be utilized by people needing help, and for procedures to be developed for reporting the services to a central agency.

Local communities must become aware of the changing situation and of the emergence of new problems and needs. Studies to isolate, identify, and measure these needs must be undertaken in order that an effective plan of action may be adopted. The summary of developments in these 42 urban areas in 1941 may provide, for the registration-area cities and for other communities, a point of departure for such investigations.

FAMILY SERVICE

Services of family agencies in the 42 urban areas combined showed a reduction in 1941 as compared with 1940 in 5 of the 9 types of service included under this broad classification (table 3). The greatest decrease, amounting to one-third of the 1940 service, was reported by public family-welfare and relief agencies. A substantial decline was also reported in shelter care (20 percent) and smaller decreases occurred in legal aid, institutional care of adults, and family welfare and relief by private agencies. Increases occurred in the 3 special types of public assistance and in service and relief for transients and travelers.

Table 3.--Percentage change from 1940 in average monthly figures for selected types of family service in 42 urban areas, 1941

Type of family service	Percent change		Area reporting greatest percent		Number of areas						
	Total	Range	Increase	Decrease	Total	Reporting					
						Total	In-crease a/ b/	De-crease a/ b/	Change not computed b/	No change	No or- ganized service	Not re- porting
Family welfare and relief, private agency.....	-0.7	+34.0 -22.4	Birmingham	Dayton	42	42	18	24	.....	.....	.....
Family welfare and relief, public agency.....	-34.0	+4.5 -55.6	Washington, D. C.	Los Angeles	42	42	3	39	.....	.....	.....
Aid to dependent children.....	+14.8	+91.1 -18.6	Wilkes-Barre	Baltimore	42	41	30	10	.....	1	1
Old-age assistance.....	+9.5	+29.3 -4.7	Atlanta	Baltimore	42	41	37	4	.....	.....	1
Aid to the blind.....	+1.8	+62.6 -14.2	Atlanta	St. Louis	42	40	23	11	2	3	2
Service and relief to transients and travelers.....	+0.1	+62.5 -25.6	Louisville	Cleveland	42	40	14	17	3	1	5
Shelter care (lodgings).....	-20.1	+31.5 -85.5	Birmingham	Atlanta	42	37	6	30	.....	.....	2
Legal aid.....	-5.7	+35.1 -18.7	Kansas City, Mo.	Detroit	42	39	4	19	3	2	3
Institutional care (adults).....	-3.4	+16.6 -14.5	Dallas	Detroit	42	25	7	16	.....	1	17

a/ Exclusive of areas for which the base was less than 50.

b/ Not computed because the base was less than 50.

Table 4.--Percentage change from 1940 in average monthly figures for selected types of child-welfare services in 42 urban areas, 1941

Type of service	Percent change		Area reporting greatest percent		Number of areas							Hot re- re- porting
	Total	Range	Increase	Decrease	Total	Reporting						
						Total	In- crease a/ b/	De- crease a/ b/	Change not computed b/	No change	No or- ganized service	
Protective and foster care.	-0.3	+28.5	-7.6	Kansas City, Mo.	Cleveland	42	38	17	20	.....	1	4
In parents' homes.....	+1.8	+25.2	-36.9	Kansas City, Mo.	Birmingham	42	38	20	15	2	1	4
In relatives' homes.....	-2.2	+28.3	-17.1	Birmingham	Syracuse	42	38	13	16	8	1	4
In foster homes.....	-0.3	+26.9	-8.2	Dallas	Grand Rapids	42	38	20	17	1	.....	4
In institutions.....	-2.9	+28.4	-14.9	Sioux City	Duluth	42	38	8	30	.....	.....	4
Day-nursery care.....	+2.5	+24.6	-28.8	Buffalo	New Orleans	42	40	22	10	2	6	2
Maternity-home care.....	0.0	+52.6	-11.7	St. Louis	Cleveland	42	39	7	9	19	.....	3

a/ Exclusive of areas for which the base was less than 50.

b/ Percent change was not computed because base was less than 50.

Family welfare and relief, private agencies.

Comparable reports from 1929 to 1940 from private agencies in 116 urban areas show that private-agency responsibility for family welfare and relief reached its peak during 1932. ^{8/} Since the launching of the Federal Emergency Relief Administration early in 1933 public agencies have taken over the major responsibility for providing financial assistance while private agencies have shown an increasing responsibility for providing professional social service to cases accepted for study and treatment. In the 42 urban areas a continuation of this trend is shown in that while the average monthly number of cases reported by private agencies showed practically no change in 1941 as compared with 1940, the number of cases receiving social service only increased 10 percent and the number of cases receiving financial assistance dropped 15 percent. However, the average monthly payment increased from \$16.40 per case during 1940 to \$18.22 during 1941 (figure 3). Only 6 percent of the total payments made to family welfare and relief cases in public and private agencies combined were received through private funds.

Family welfare and relief, public agencies.

As compared with 1940 the average number of cases receiving general relief from public agencies in the 42 urban areas during 1941 dropped 34 percent. In contrast to the average experience of the combined areas, Washington, D.C., New Orleans, and Louisville showed increases in average monthly number of cases. The general reduction in 1941 was a continuation of the downward movement that started in 1940. Although the number of cases assisted by public agencies decreased sharply, the average monthly payment per case was practically the same during the 2 years, being \$26.60 in 1940 as compared with \$25.97 in 1941 (figure 3).

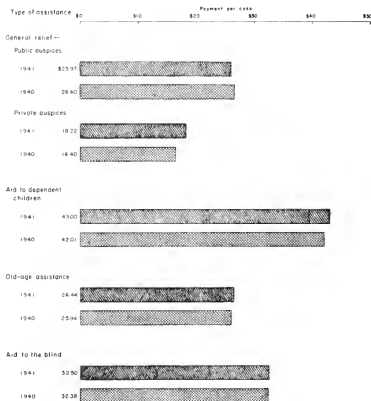
Special types of public assistance.

In 1935 the Social Security Act authorized Federal grants for three special types of public assistance—old-age assistance, aid to dependent children, and aid to the blind—to States with plans approved by the Social Security Board. Each program as reported to the Social Security Board by 116 urban areas combined has shown a continued expansion since 1935. From 1940 to 1941 the combined reports from the 42 urban areas ^{9/} showed an increase of 15 percent in the average monthly number of aid-to-dependent-children cases, an increase of 10 percent in the average monthly number of old-age-assistance cases, and an increase of 2 percent in the average monthly number of aid-to-

the-blind cases (table 3). Each type of special assistance case showed some increase in the average monthly payment granted (figure 3). During 1941 the total payments for old-age assistance in the 42 areas combined amounted to more than 3 times the amount paid for aid to dependent children and more than 20 times the amount paid for aid to the blind. On the basis of the 1940 census population for the combined areas the annual payments in 1941 for old-age assistance averaged \$4.43 per capita; for aid to dependent children, \$1.28 per capita; and for aid to the blind, \$0.21 per capita.

Percentage changes from 1940 to 1941 as reported by the urban areas individually showed wide variations; in aid-to-dependent children, from an increase of 91 percent in Wilkes-Barre to a decrease of 19 percent in Baltimore; in old-age assistance, from an increase of 99 percent in Atlanta to a decrease of 5 percent in Baltimore; and in aid to the blind, from an increase of 63 percent in Atlanta to a decrease of 14 percent in St. Louis.

FIG 3—AVERAGE MONTHLY PAYMENT PER CASE BY TYPE OF ASSISTANCE IN 42 URBAN AREAS, 1941 AND 1940



Service and relief to transients and travelers.

During 1940 and 1941, 40 of the 42 urban areas reported comparable statistics showing the volume of case-work service and relief to transients and travelers. However, the number of persons receiving only information, direction, or referral service was not reported on the monthly

^{8/} Social Security Bulletin, February 1941, p. 80. Federal Security Agency, Washington, D.C.

^{9/} By the end of 1941 each of the 42 urban areas had programs providing each type of special assistance, except that there was no program of aid to the blind in Louisville.

summaries prepared for the Children's Bureau. 10/

Four of every 5 agencies reporting this type of service in 1941 were affiliated with the National Travelers Aid Association. During 1941 a monthly average of 12,249 cases were reported as receiving case-work service and relief in this special type of separately organized community service for transients and travelers. As compared with 1940 this figure represented practically no change. Unattached individuals comprised approximately three-fourths of the total number of cases reported. Slightly less than two-thirds (64 percent) of the total cases reported were classified as receiving service only. Service-only cases in 1941 showed an increase of 12 percent over 1940, and cases receiving financial assistance showed a decrease of 16 percent. Financial assistance to transients and travelers (exclusive of shelter care) averaged \$6.28 per case per month in 1941 and \$8.80 per case in 1940.

Shelter care for homeless or transient persons.

Reports in the field of shelter care show that the year 1935 was the all-time high for this type of service. 11/ The 1935 peak was attributable in large measure to the availability of Federal funds for this service from 1933 through 1935. During 1936, with the withdrawal of Federal funds, the number of meals and lodgings reported dropped approximately 65 percent. From the low point of 1936 a gradual increase was recorded in shelter care through 1938. A downward movement began in 1940, and by 1941 a marked reduction was reported in shelter-care service, amounting to one-fourth of the 1940 volume of meals and one-fifth of the 1940 volume of lodgings (appendix table 2).

Shelter-care auspices.

In contrast with the family welfare and relief program where public responsibility continued to be predominant after the withdrawal of Federal funds, shelter-care programs were continued after the close of 1935, primarily through private agencies. In 1941 approximately two-thirds of the

10/ As previous analyses of this type of separately organized program of service and relief to transients and travelers have indicated the relative numerical prominence of the information, direction, and referral service, it is important that the exclusion of this type of service be kept in mind when reviewing the tabulations given in this article. Furthermore, it should be noted that meals and lodgings provided to transients and travelers as a separately organized type of service are reported in the field of shelter care and not in this field.

11/ Meals and lodgings provided by self-supporting agencies and commercial lodging houses operated for persons of low income are not included in the tabulations discussed in this article. Agencies included in this classification provide separately organized shelter care for homeless and transient persons in need on a temporary basis.

shelter care provided in the 42 urban areas was reported by private agencies, including the Salvation Army, Volunteers of America, Catholic, Protestant, and Jewish agencies, and nonsectarian agencies such as missions and sailors' homes. Moreover, the percentage decrease from 1940 reported in 1941 was considerably less for private agencies than for public agencies (appendix table 2). The average monthly number of meals provided by public agencies in 1941 showed a decrease of 39 percent; but the decrease shown by private agencies was only 10 percent. Public agencies reported a 38-percent decrease in lodgings provided while private agencies showed a decrease of only 6 percent.

CHILD WELFARE

The types of child-welfare work discussed in this section are protective and foster care of dependent and neglected children, day-nursery care, and maternity-home care. Other important services to children are presented in other sections of this article. Aid to dependent children is considered under the section on family welfare and relief. Child-guidance service provided in mental-hygiene clinics, physical examination of school children, and other health services to children are included in the health section. The group-work services of private agencies, including nursery-school and kindergarten programs (as distinguished from day-nursery care provided to meet a family need) are reported in the group-work field. 12/

Services provided during 1941.

During the year 1941 the average number of children receiving protective and foster care on the last day of the month was 104,349; day-nursery care, 8,398 children; and the average number of women under care in maternity homes, 1,987. 13/ The distribution of these 113,000 children and 2,000 women by type of service and by agency auspices shows that 36 percent of the total number under care were children who received protective care and supervision while living in the homes of their parents or relatives; 33 percent received foster-home care; 22 percent, care in institutions for

12/ Other important services provided for children by agencies in the reporting areas but not covered by this article include special types of care for physically and mentally handicapped children, care and treatment of delinquent children, public-agency programs that provide day care of children, and self-supporting and commercially operated programs serving children.

13/ All statistics included in this analysis were adjusted by residence of the children by the various urban areas reporting these services. However, all women under care of maternity homes, whether or not they were residents of the registration area, were considered for purposes of these tabulations as being the responsibility of the reporting area.

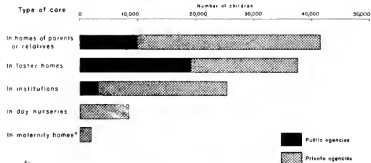
dependent and neglected children; 7 percent, day-nursery care; and 2 percent were women under care in maternity homes.

Public-agency administration predominated in foster-home programs for children but was not apparent in day-nursery and maternity-home care (figure 4). Responsibility in public agencies for the direct care of dependent and neglected children had not been established by January 1940 in Detroit, Cincinnati, San Francisco, and Grand Rapids. However, during the latter part of 1940, Cincinnati organized a public-agency program. The first direct services reported by this agency covered the month of January 1941. ¹⁴ Thirteen areas reported no institutional care for dependent and neglected children provided by public agencies. Canton was the only area that reported no private agency operating an institution for the care of dependent and neglected children. Six of the 42 areas reported that no day-nursery program was in existence during the years 1940 and 1941 (table 4, p. 7). These areas were Akron, Canton, Des Moines, Duluth, Grand Rapids, and Wilkes-Barre.

Percentage change from 1940.

During 1941 the average monthly number of children receiving protective and foster-care or

FIG 4 - AVERAGE MONTHLY NUMBER OF CHILDREN RECEIVING CHILD-WELFARE SERVICES BY SELECTED TYPES OF CARE IN 38 URBAN AREAS, 1941



public agencies showed an increase of 3 percent and private agencies showed a decrease of 1 percent, the continuation of a trend that has been apparent for some years. However, the number of dependent and neglected children receiving care in public institutions decreased (table 5). In contrast, although the average monthly number of children in all foster homes in 1941 was practically the same as in 1940, public-agency programs showed a 4-percent increase, and private-agency programs showed a decrease of 4 percent. In 1940 public agencies administered 49 percent of the total foster-home service and in 1941, 51 percent.

Table 5.—Average monthly number of children receiving child-welfare services by selected types of care and by agency auspices in 38 urban areas, 1941

Type of care	Total		Auspices		Percent change from 1940 in--		
	Number	Percent	Public	Private	Total	Auspices	
						Public	Private
Total persons.....	114,734	100.0	32,076	82,658	-0.1	+2.9	-1.2
Protective and foster care, total.....	104,349	91.0	32,076	72,273	-0.3	+2.9	-1.7
In parents' homes.....	35,652	31.0	7,307	28,345	+1.8	+5.8	+0.9
In relatives' homes.....	5,843	5.0	2,506	3,337	-2.2	-0.2	-3.6
In foster homes.....	37,537	33.0	19,128	18,409	-0.3	+3.6	-4.0
In institutions.....	25,317	22.0	3,135	22,182	-2.9	-5.0	-2.5
Day-nursery care.....	8,398	7.0	.....	8,398	+2.5	.....	+2.5
Maternity-home care ^{a/}	1,987	2.0	.....	1,987	.....	.....	.....

^{a/} Women.

day-nursery care, and women receiving maternity-home care was practically the same (-0.1) as the corresponding figure for 1940 (table 5). However,

^{14/} The extent to which public funds supported the various types of child-welfare services in 1941 was not reported. However, previously published reports have indicated that public funds represent an important proportion of the total funds received by private agencies for children. See *Social Statistics*, Dec. 1940, p. 14, and The Community Welfare Picture, June 1939 and June 1941.

Foster-home care in individual areas.

When examined by individual area, the trends in private and public foster-home care showed considerable variation. Reports from 18 of the areas indicated a percentage increase in public-agency programs ranging from 0.9 percent in Buffalo to 60.0 percent in Dallas (table 6). In addition, one area (Cincinnati) initiated a public-agency foster-home program early in 1941. Three areas (San Francisco, Detroit, and Grand Rapids) reported that no public agency administered care to

Table 6.--Average monthly number of children receiving foster-home care on last day of month in 38 urban areas, 1941

Area	Total	Ages		Percent change from 1940 in--		
		Ages		Total	Ages	
		Public	Private		Public	Private
Total, 38 areas.....	37,537	19,128	18,409	-0.3	+3.6	-4.0
Chicago.....	5,398	1,575	3,823	+0.1	-1.9	+1.0
Los Angeles.....	2,304	1,392	912	-1.4	-0.6	-2.7
Detroit.....	2,777	.....	2,777	-2.0	.....	-2.0
Pittsburgh.....	2,119	1,665	454	-7.3	-7.6	-6.4
Cleveland.....	3,128	2,436	692	-3.7	-4.2	-1.7
St. Louis.....	1,913	1,295	618	+1.1	-1.4	+6.7
Baltimore.....	1,145	256	889	-6.3	a/	-25.2
Buffalo.....	1,785	1,392	393	-1.3	+0.9	-8.6
Milwaukee.....	826	232	594	+6.6	+12.1	+4.6
Washington, D. C.....	1,290	1,141	149	+1.9	0	+1.9
San Francisco.....	1,479	.....	1,479	-0.2	.....	-0.2
Cincinnati.....	913	347	566	+1.7	b/	-37.0
Houston.....	430	58	372	+15.3	+9.4	+16.3
Minneapolis.....	946	379	567	-1.9	+13.5	-10.0
New Orleans.....	218	127	91	+23.2	+47.7	0
Atlanta.....	433	256	177	+13.1	+8.5	+20.4
Kansas City, Mo.....	353	155	198	+16.5	+12.3	+20.0
Indianapolis.....	1,383	1,080	303	+0.4	+5.8	-15.1
Birmingham.....	346	208	138	+0.6	+3.5	-3.5
Dallas.....	137	80	57	+26.9	+60.0	-1.7
Columbus.....	468	291	177	-3.9	+3.6	-14.1
Louisville.....	709	561	148	-6.0	-9.7	+11.3
Akron.....	298	142	156	+11.2	+20.3	+4.0
Denver.....	530	286	244	-2.2	-1.4	-3.2
St. Paul.....	1,169	655	514	+5.7	+10.6	0
Dayton.....	442	212	230	-2.4	-4.9	0
Richmond.....	373	176	197	+4.2	+17.3	-5.3
Providence.....	599	446	153	-2.3	-4.3	+4.1
Hartford.....	749	526	223	-1.6	+2.9	-10.8
Omaha.....	224	54	170	+5.2	-8.5	+10.4
Grand Rapids.....	78	.....	78	-8.2	.....	-8.2
Canton.....	533	222	311	+3.7	+57.4	-16.6
New Haven.....	641	519	122	-4.3	-2.1	-12.9
Syracuse.....	536	413	123	-4.6	-1.4	-14.0
Des Moines.....	215	72	143	+10.3	+26.3	+3.6
Wichita.....	147	11	136	+14.0	a/	+14.3
Sioux City.....	32	16	16	a/	a/	a/
Duluth.....	472	453	19	+8.3	+6.8	a/

a/ Not computed because the base was less than 50.

b/ Area reported no children under care of public agencies prior to January 1941.

children in foster homes; however, each of these areas reported a decrease in private-agency foster-home service. Twelve areas reported a decrease in public-agency service, ranging from 1.4 percent in St. Louis to 9.7 percent in Louisville.

Institutional care.

The combined areas showed a decrease of 2.9 percent in 1941 as compared with 1940 in institutional care of dependent and neglected children.

Thirty areas reported a decrease ranging from 0.1 percent in Baltimore to 14.9 percent in Duluth. On the other hand, 8 areas reported an increase in this type of care ranging from 0.2 percent in Dallas to 28.4 percent in Sioux City. A steady decline in institutional care for dependent and neglected children has been reported for several years. 15/

Day-nursery care.

The combined areas showed a 2.5-percent increase in day-nursery care in 1941 as compared with 1940. Twenty-two areas showed an increase in the number of children receiving day-nursery care during 1941. The percentage increase ranged from 0.8 percent in Atlanta to 24.6 percent in Buffalo. Fourteen of these 22 areas showed an increase of 5 percent or more. On the other hand, 10 areas showed a decrease, ranging from 1.1 percent in Louisville to 29.8 percent in New Orleans.

Maternity-home care.

Comparable reports for the years 1937 through 1941 show a small but steady decrease in the number of women receiving maternity-home care. ^{16/} However, from 1940 to 1941 there was no change in this type of care for the combined reporting areas.

Individually, the areas showed considerable variation from the average reported for all areas. The greatest percentage increase in 1941 as compared with 1940 was reported by St. Louis (53 percent), and the greatest decrease was shown by Cleveland (12 percent).

HEALTH

In terms of the average monthly volume of service provided, the reports for the various programs included in the health field for 1941 in the 42 areas may be ranked in the following descending order of importance: Hospital in-patient; clinic; public-health nursing; school hygiene; mental-hygiene clinic; medical service in patient's home and in doctor's office, and medical-social service. Hospital in-patient service showed the usual preponderance, being twice as large as any of the other services. All of these services were

Table 7.--Average monthly figures for selected types of health service by auspices in 42 urban areas, 1941

Type of service	Total	Auspices		Percent change from 1940 in--		
		Public	Private	Total	Auspices	
					Public	Private
Hospital patient-days:						
General and special.....	2,188,436	693,422	1,495,014	+4.3	-2.7	+7.9
Tuberculosis.....	323,351	291,351	32,000	+2.5	+3.5	-5.9
Chronic illness.....	19,730	.....	19,730	+6.1	.....	+6.1
Medical service:						
Clinic visits ^{a/}	1,322,793	749,575	573,218	-6.3	-7.4	-4.9
Home visits.....	46,109	44,993	1,116	-12.1	-11.5	-32.3
Examinations ^{b/}	86,557	85,695	862	-2.3	-2.5	+15.1
Mental-hygiene-clinic cases.....	5,353	1,541	3,812	-5.0	-5.9	-4.7
Public-health-nursing visits, total ^{c/}:						
Maternity-care visits.....	467,680	267,432	200,248	-0.5	-0.4	-0.6
.....	63,878	20,445	43,433	-1.1	-3.7	+0.1
Medical-social service (patients).....	39,550	16,083	23,467	-3.1	-3.5	-2.8

^{a/} Does not include visits to separately organized mental-hygiene clinics.

^{b/} Limited to separately organized school health programs.

^{c/} Includes both field and office visits except office visits provided in separately organized school health programs.

^{16/} Maternity-home care is distinguished from maternity-hospital in-patient care in that maternity-home care is a type of continued institutional care provided to women requiring such care preceding and following childbirth, whereas maternity-hospital in-patient care is usually limited to care at the time of delivery and the lying-in period. A large number of maternity homes, however, provide delivery service in the home in addition to institutional care before and after the birth of the child. The average length of stay of women admitted to maternity-hospital in-patient service was 10 days for the period January-June 1940, but the average length of stay of women admitted to maternity-home care during 1940 was 94 days.

administered in part by public and in part by private agencies. Public agencies administered the larger part of two types of services: Clinic visits (other than separately organized mental-hygiene clinics) and public-health-nursing service (table 7).

There was a decline in 1941 in the volume of each of the selected health services except hospital in-patient service, and in this field the 4-percent increase (in total service) was accounted for entirely by private hospital service.

Among the individual areas, however, the change from 1940 to 1941 showed wide variations from the combined monthly averages, especially in tuberculosis hospital service, physical examinations by physicians in school-health programs, and

Table 8.--Percentage change from 1940 in average monthly figures for selected types of health service in 42 urban areas, 1941

Type of service	Percent change		Area reporting greatest percent		Number of areas							
	Total	Range		Increase	Decrease	Total	Reporting					
		From	To				In- crease a/	De- crease a/	Change not computed b/	No or- ganized service		
											No change	
Hospital patient days:												
General and special	+4.3	+20.9	-2.1	Canton	Richmond	42	30	25	5			12
Tuberculosis	+2.5	+76.3	-21.9	San Francisco	Dayton	42	30	17	11		2	12
Chronic illness	+6.1	+27.8	+2.1	St. Louis	c/	42	30	4			26	12
Medical service:												
Clinic visits d/	-6.3	+10.6	-18.5	Omaha	Grand Rapids	42	38	8	30			4
Home visits	-12.1	+22.5	-60.4	Kansas City, Mo.	New Orleans	42	25	8	16		1	17
Examinations g/	-2.3	+98.4	-76.9	Wichita	New Orleans	42	35	17	13	1	2	7
Mental-hygiene-clinic cases	-5.0	+18.3	-36.1	St. Louis	Washington, D. C.	42	36	9	14	6	7	6
Public-health-nursing visits f/, total	-0.5	+18.8	-16.9	Akron	Sioux City	42	35	15	20			7
Maternity-case visits	-1.1	+25.8	-26.6	Houston	Akron	42	35	15	20			7
Medical-social service (patients)	-3.1	+143.3	-37.5	Atlanta	Richmond	42	34	5	19	1	9	8

a/ Exclusive of areas for which the base was less than 50.

b/ Not computed because the base was less than 50.

c/ No area showed a decrease.

d/ Does not include visits to separately organized mental-hygiene clinics.

e/ Limited to separately organized school health programs.

f/ Includes both field and office visits except office visits provided in separately organized school health programs.

medical-social service (table 8, p. 13). In each type of service a substantial increase was found in a number of areas.

Hospital in-patient service.

Hospital in-patient services included in this article are classified in three groups by type of hospital: i.e., general and special, tuberculosis, and chronic illness.^{17/} Public hospitals accounted for about one-third of the total patient-days reported by general and special hospitals and for about nine-tenths of the total patient-days reported by tuberculosis hospitals. None of the hospitals for chronic illness that reported are under public auspices. The proportion of patient-days provided free to patients was 42 percent in general and special hospitals, 92 percent in tuberculosis hospitals, and 53 percent in hospitals for chronic illness (table 9).

Reports received from general and special hospitals in a smaller number of urban areas for the period covering 1936 through 1939 showed a steady expansion in the number of patient-days provided by general and special hospitals. This increase, however, was limited to private hospitals, which showed an increase of 11 percent between 1936 and 1939. Public hospitals showed no change in the volume of patient-days during that period.^{18/} While this general upward trend continued through 1941 for private hospitals in the 30 areas included in this article, public hospitals reported a slight decrease (2.7 percent) in the number of patient-days provided in 1941 as compared with 1940. Of special interest is the fact that although total days' care increased in private hospitals, the free days' care provided by these hospitals decreased more (8.5 percent) than free days' care in public hospitals (4.5 percent). (See appendix table 2.)

Maternity cases and children under 14 years of age (exclusive of live births) accounted for about one-third of the total admissions to general and special hospitals during 1941. For the combined reporting areas the number of maternity cases admitted increased 17 percent during 1941 as compared with 1940. Furthermore, every area showed an increase in the number of maternity cases admitted to hospital care. The greatest increase was reported by hospitals in Canton (30 percent) and the smallest increase (7 percent) by those in Wilkes-Barre. Table 10 shows the number of maternity cases and children under 14 years of age admitted, and the number of live births reported by general and special hospitals for each area. Public hospitals reported an increase of 7 percent in maternity cases admitted during 1941, and private hospitals reported a 19-percent increase. Seven of the 30 areas reported that no maternity cases

^{17/} Among the hospital in-patient services excluded from the figures presented in this article are services provided by hospitals organized for profit, industrial hospitals, hospitals caring for the insane, feeble-minded, epileptic, blind, or deaf, and hospitals for marines and ex-soldiers.

^{18/} Social Statistics, September 1940 (p. 14).

were admitted to public hospitals. In 3 other areas there are no public hospitals.

Health services other than hospital in-patient service.

A summary of the average monthly count of the selected professional health services presented in this article is given in table 7. Ranked in the order of the volume of service reported, these services other than hospital in-patient service include visits to clinics (other than separately organized mental-hygiene clinics), public-health-nursing visits, physical examinations of children by physicians in separately organized school-health programs, home medical visits, medical-social service, and cases served by mental-hygiene clinics.^{19/}

Clinic service.—During 1941 the average monthly number of visits to clinics in the 38 reporting areas amounted to almost one and a third million visits (1,322,793). This number represented a decrease of 6 percent from that reported for 1940 and a continuation of the decline from the peak year, 1939.^{20/} Thirty of the 38 areas reporting comparable figures for the years 1940 and 1941 showed a decrease in the number of clinic visits during 1941. The variations among individual areas from the average decrease of 6 percent for the 38 areas combined ranged from a decrease of 19 percent in Grand Rapids to an increase of 11 percent in Omaha (table 8).

Public-health-nursing service.—The average monthly number of public-health-nursing visits reported for the 35 reporting areas was nearly half a million (467,680). Visits to maternity cases accounted for 14 percent of the total visits. Private agencies reported more than

^{19/} The statistical unit of service counted for each type of health program other than hospital in-patient care is the professional service provided to an individual (except for mental-hygiene clinics where the count is the case served). Professional services which are the bases of statistical count include: Medical service provided during a patient's visit for clinic other than mental-hygiene clinic; physical examinations given by physicians for the school health program; home visits made by physicians for the medical-care program; and home and office visits provided by nurses for the public-health-nursing program. The unit of count for medical-social services is the patient who receives medical-social service by a staff member of the medical-social-service department of a hospital or clinic.

^{20/} "The average monthly number of clinic visits during 1940 was 17 percent above the average for 1936 and only slightly below that in the year 1939, when the highest figure was reached. The increase over the 5-year period took place almost entirely in 1938 when the number of visits to both public and private clinics rose markedly, averaging 15 percent over the number in the preceding year." Social Statistics, December 1941 (p. 13).

Table 9.—In-patient service provided by hospitals of specified types in 30 urban areas, 1941

Type of hospital and auspices	Number of hospitals	Number of admissions a/	Number of patient-days		
			Total	Free to patient	
				Number	Percent of total
General and special.....	385	1,937,220	26,261,227	11,121,257	42
Public.....	57	451,632	8,321,058	7,583,183	91
Private.....	328	1,485,588	17,940,169	3,538,074	20
Tuberculosis.....	43	13,278	3,880,207	3,560,344	92
Public.....	31	11,313	3,496,210	3,311,771	95
Private.....	12	1,965	383,997	248,573	65
Chronic illness (private).....	7	387	236,760	125,576	53

a/ Exclusive of live births.

Table 10.—Number of admissions of maternity cases and children under 14 years of age, and number of live births as reported by general and special hospitals in 30 urban areas, 1941

Urban area	Admissions		Live births	Percent change from 1940 in--		
	Maternity cases	Children under 14 years of age		Admissions		Live births
				Maternity cases	Children under 14 years of age	
Total, 30 areas.....	310,512	310,672	280,299	+16.7	+1.0	+16.2
Public auspices.....	58,969	80,651	46,956	+6.6	+0.6	+5.2
Private auspices.....	251,543	230,021	233,343	+19.3	+1.2	+18.8
Chicago.....	54,077	54,645	48,094	+17.0	-0.3	+16.8
Detroit.....	30,114	27,154	28,492	+19.6	+15.8	+19.2
Pittsburgh.....	22,295	19,424	20,435	+16.2	-4.3	+16.3
Cleveland.....	19,760	14,952	17,921	+19.9	-0.1	+19.3
St. Louis.....	17,536	16,458	15,673	+15.5	+4.0	+14.6
Baltimore.....	16,650	17,463	14,925	+17.1	-7.9	+17.0
Buffalo.....	12,092	10,816	11,340	+18.7	+1.8	+20.1
Milwaukee.....	11,427	15,338	10,869	+14.1	+2.5	+13.2
Washington, D. C.....	13,327	13,136	12,251	+15.0	-1.4	+13.6
San Francisco.....	8,941	10,767	8,104	+9.8	+4.9	+10.1
New Orleans.....	14,283	24,332	11,627	+19.7	+3.5	+17.2
Atlanta.....	8,655	4,994	7,652	+7.6	-1.4	+10.6
Kansas City, Mo.....	7,108	7,673	6,347	+13.1	-9.5	+9.1
Indianapolis.....	8,020	9,725	7,062	+16.2	-2.1	+13.4
Birmingham.....	4,523	5,761	3,887	+18.7	+8.4	+14.5
Dallas.....	6,895	6,222	5,829	+16.1	+7.4	+15.3
Columbus.....	6,093	5,002	5,719	+17.4	-6.0	+16.8
Akron.....	5,255	4,979	4,906	+22.7	-8.5	+21.4
St. Paul.....	6,262	8,478	5,748	+9.4	+3.1	+7.3
Dayton.....	5,545	3,211	5,191	+19.9	-1.5	+22.4
Richmond.....	3,010	3,854	2,058	+28.0	+23.7	+29.2
Grand Rapids.....	3,525	3,093	3,219	+16.4	-2.9	+17.1
Canton.....	4,168	1,973	3,883	+30.3	+12.1	+30.2
New Haven.....	3,738	2,921	3,558	+15.4	-4.5	+17.5
Wilkes-Barre.....	2,403	2,680	2,079	+6.9	+5.2	+11.2
Syracuse.....	4,736	4,460	4,167	+14.4	a/	+14.4
Des Moines.....	2,741	3,286	2,571	+8.5	-7.0	+9.0
Springfield, Mass.....	3,311	3,405	3,015	+20.3	-0.5	+21.8
Sioux City.....	1,838	2,252	1,692	+16.3	-6.7	+15.6
Duluth.....	2,184	2,218	1,985	+10.0	-5.1	+10.6

a/ Less than 0.05 percent.

Table 11.--Percentage changes from 1940 in average monthly figures for selected statistics of group work, and the social-service exchange, in 42 urban areas, 1941

Type of service	Percent change		Area reporting Greatest percent		Number of areas						Hot re- re- porting
	Total	Range From To	Increase	Decrease	Total	Reporting					
						Total	In- crease	De- crease	Change not computed	No or- no caused service	
Attendance at group activities other than Boy Scout, Girl Scout, and Camp Fire Girl programs.....	-1.2	+39.7 -20.8	Richmond	New Haven	42	30	10	20	.....	.....	12
Members of Boy Scout, Girl Scout, and Camp Fire Girl Councils.....	+5.2	+25.1 -4.8	Houston	Providence	42	36	29	7	.....	.....	6
Boy Scouts.....	+4.5	+27.7 -11.1	Houston	Wilkes-Barre	42	36	25	11	.....	.....	6
Girl Scouts.....	+6.7	+46.6 -9.9	Dallas	Sioux City	42	36	28	7	.....	.....	6
Camp Fire Girls.....	+6.0	+57.1 -12.5	Cincinnati	Syracuse	42	39	14	6	.....	.....	3
Social-service-exchange clearings.	-9.1	+93.4 -42.5	Oakaba	Grand Rapids	42	41	9	32	.....	.....	1

twice as many visits of this type (43,433) as did public agencies (20,445). However, public agencies reported 57 percent of the total number of public-health-nursing visits (appendix table 2). The total volume of nursing visits during 1941 as compared with 1940 showed a decrease of less than 1 percent and reflects the continuation of a slightly downward trend which began in 1939. Comparable statistics from 17 areas show that the number of visits during 1940 was lower than in any of the 3 preceding years and was 4 percent lower than in 1939.

GROUP WORK

During the year 1941 total attendance at group activities as reported by 304 established private agencies showed a slight decrease (-1.2 percent) as compared with the attendance reported by the same agencies for the year 1940 (table 11). This decrease represented the continuation of a slight downward movement shown in reports received from a smaller number of agencies for the period 1938-42. ^{21/} Tabulated separately and not included in either of these attendance summaries were the monthly reports of membership in Boy Scout, Girl Scout, and Camp Fire Girl programs.

Including a count of the Boy Scout, Girl Scout, and Camp Fire Girl councils, the 30 urban areas reporting the group-work service of private agencies submitted monthly reports from 375 agencies. More than half of these agencies (191) were identified as settlements and centers, the other half included Y.M.C.A.'s (31), Y.W.C.A.'s (33), Boy Scouts (28), Girl Scouts (28), Camp Fire Girls (15), boys' clubs (14), and 35 other agencies. ^{22/} (See table 12).

For the 30 areas reporting in the broad field of group work, the unduplicated counts of members (cumulative) are available for 1940 but are incomplete for 1941. However, assuming that the 1940 ratio of 31 attendances at organized, definitely scheduled groups to cumulative membership ^{23/} would be approximately correct for 1941, the combined cumulative membership figure for the 304 agencies reporting in 1941 would total an estimated 816,115 persons as compared with an estimated total of 817,113 persons in 1940. Similarly, if the ratio of 1.5 members per council per month obtaining in

^{24/} Social Statistics, Dec. 1941 (pp. 4 and 5).

^{25/} Statistics of group-work activity are limited because the activities of this broad field of service are difficult to adapt to statistical units of count. Statistical definition of the field itself is perhaps even more difficult. Tabulations presented in this article do not include reports of public-agency group-work service, primarily because statistical definitions covering the wide range of activities supervised by public agencies directing leisure-time programs have not yet been satisfactorily formulated.

^{26/} Social Statistics, December 1941 (p. 10).

Table 12.--Estimated cumulative membership based on reports received from private group-work agencies in 30 urban areas, 1941

Type of organization	Number of agencies	Urban areas represented	Estimated cumulative membership
Total.....	375	30	1,298,249
Total, other than Boy Scout, Girl Scout, and Camp Fire Girl councils..	304	30	816,115
Settlements and centers.	191	28	
Y.M.C.A.....	31	28	
Y.W.C.A.....	33	29	
Boys' clubs.....	14	11	
Other.....	35	22	
Total Boy Scout, Girl Scout, and Camp Fire Girl councils.....	71	28	482,134
Boy Scouts.....	28	28	
Girl Scouts.....	28	28	
Camp Fire Girls.....	15	15	

1940 were carried into 1941, the cumulative membership figure for the 71 Boy Scout, Girl Scout, and Camp Fire Girl councils reporting in 1941 would total an estimated 482,134 persons as compared with an estimated total of 458,162 persons in 1940. ^{24/}

The average monthly membership in Boy Scout, Girl Scout, and Camp Fire Girl organizations in the combined 36 areas reporting totaled 324,552 during 1941. ^{25/} This figure represented a 5-percent increase as compared with 1940 (table 11).

Seven of the areas, however, reported decreases, all of which were less than 5 percent. Of the 29 areas showing increases 12 areas reported increases of less than 5 percent and only 5 areas reported increases of more than 10 percent. The largest increase was reported by Houston (25 percent).

^{26/} In addition, the summary tabulations included membership reports for Boy Scouts from Atlanta, Boston, Buffalo, Los Angeles, Newark, Pittsburgh, Grand Rapids, and Wilkes-Barre; for Girl Scouts from the same areas except Grand Rapids; and for Camp Fire Girls from the same areas except Newark, Pittsburgh, and Wilkes-Barre.

^{27/} This figure represented about 17 percent of the boy and girl membership reported for the United States by all Boy Scout, Girl Scout, and Camp Fire Girl councils.

Appendix table 1.—Average monthly figures for selected types of

Area a/	Private agency cases	Transient and traveler cases	Family welfare and relief					Child-welfare service									
			Cases receiving public assistance				Institutional care		Children under protective and foster care								
			Public general relief	Special types of assistance			Day-care to adults	Shelter	Legal-aid cases opened	Total	In parents' homes	In relatives' homes	In foster homes	In institutions	Children on dependency registry	Women under care in maternity hospitals	
				Aid to dependent children	Old-age assistance	Aid to the blind											Males	Female
All areas reporting, total.	73,412	12,249	296,279	66,045	372,701	19,299	481,963	371,435	119,541	1,543	32,076	7,307	2,566	19,128	3,115	6,398	
Public agencies.....	73,412	8,292	296,279	66,045	372,701	19,299	481,963	371,435	119,541	1,543	32,076	7,307	2,566	19,128	3,115	6,398	
Private agencies.....		5,157					37,127		225,341		12,741						
Chicago.....	8,845	1,070	66,467	2,530	52,120	2,203	217,556	82,265	31,268	1,110	12,229	1,724	297	5,196	4,610	1,188	
Los Angeles.....	8,241	905	22,193	4,681	64,694	1,431	81	101,433	32,376	324	5,772	1,557	173	2,304	1,738	662	
Detroit.....	2,054	2,071	17,918	7,512	15,128	228	125,789	67,125	20,561	1,693	9,921	5,806	326	4,777	1,012	59	
Pittsburgh.....	4,006	248	25,041	6,513	13,450	1,768	114,812	32,216	364	7,082	5,021	1,034	2,119	1,508	99	85	
Cleveland.....	1,178	575	15,469	1,520	10,515	405	61	60,958	18,718	472	6,045	1,668	290	1,328	599	50	
St. Louis.....	2,905	417	5,606	2,955	14,159	561	61	64,885	22,165	81	4,066	853	115	1,913	1,185	492	
Baltimore.....	2,917	463	6,026	3,244	7,134	387	55,059	6,177	8,110	409	2,440	355	101	1,145	639	264	
Buffalo.....	1,547	150	10,821	1,154	4,517	142	51,452	61,054	26,649	428	4,510	1,146	405	1,785	1,174	71	
Boston.....	2,562	582	12,747	4,296	15,154	342	25,659	14,926	819	819	819	819	819	819	819	123	
Milwaukee.....	3,595	175	11,561	2,077	9,491	370	45,553	17,955	10,107	241	2,383	386	175	826	592	48	
Washington, D. C.....	2,151	1,176	2,160	385	3,505	215	81	71,793	5,036	197	2,557	214	296	1,290	777	222	
San Francisco.....	3,599	211	6,212	1,593	11,734	580	71,793	5,036	6,049	327	3,220	769	79	1,479	893	499	
Cincinnati.....	2,913	358	7,082	816	3,688	261	81	39,058	11,988	529	6,283	3,867	652	913	851	282	
Houston.....	939	156	14,467	16	8,996	113	5,715	7,616	2,394	81	1,131	285	86	430	350	62	
Minneapolis.....	8,71	640	1,235	1,534	11,500	220	27,280	81	187	4,664	3,278	287	946	153	96	99	
New Orleans.....	766	110	2,615	3,945	4,914	332	31,319	5,955	3,108	34	1,957	862	157	218	720	338	
Atlanta.....	974	162	2,185	691	4,687	187	11,142	1,674	529	255	912	103	77	413	299	373	
Kansas City, Mo.....	1,137	304	4,134	367	11,003	370	31,117	59,109	14,048	1,021	1,386	412	91	553	270	221	
Indianapolis.....	1,160	88	3,552	2,094	7,969	314	27,171	17,963	11,428	61	2,129	448	226	1,383	332	199	
Birmingham.....	331	236	81	1,137	2,018	87	7,136	1,300	1,108	81	769	101	77	362	245	151	
Denver.....	1,164	110	7,967	81	4,063	165	1,378	4,063	15,021	81	81	81	81	81	81	81	
Delaware.....	783	80	578	95	8,010	165	1,378	1,378	10,123	81	81	81	81	81	81	81	
Columbus.....	897	931	5,008	445	6,150	306	13,022	14,405	6,187	38	1,153	189	47	468	447	217	
Louisville.....	742	494	1,474	385	4,011	1	5,851	6,937	757	2,080	449	138	798	784	87	33	
Akron.....	1,068	1	1,827	287	3,991	89	8,491	14,087	4,826	81	980	190	66	298	246	81	
Des Moines.....	1,061	318	3,145	1,853	11,764	100	81	81	233	2,170	1,143	91	530	606	313	65	
St. Paul.....	1,592	123	4,977	774	5,014	127	30,721	710	409	57	2,768	1,295	109	1,169	134	173	
Grand Rapids.....	462	47	2,223	335	5,087	128	5,463	423	256	81	1,102	917	93	442	350	96	
Richmond.....	639	169	1,045	471	1,450	92	20,230	3,297	1,702	81	861	196	59	373	271	95	
Providence.....	538	101	2,862	488	2,999	41	15,973	14,578	5,237	71	2,851	1,728	205	599	315	350	
Hartford.....	793	153	1,360	133	2,545	92	81	81	113	1,396	270	75	749	296	81	30	
Omaha.....	550	41	1,975	1,423	4,118	120	13,795	4,196	1,056	81	868	279	29	224	136	79	
Grand Rapids.....	476	81	1,561	961	9,111	95	81	11,118	4,055	308	237	75	5	78	79	81	
San Antonio.....	133	45	1,103	265	4,022	93	8,796	4,530	2,094	81	1,168	363	83	533	189	81	
New Haven.....	906	81	1,611	183	2,783	57	81	14,504	7,776	246	1,146	209	21	641	275	256	
Wilmington.....	1,071	88	5,426	2,468	2,496	373	81	4,501	3,166	81	81	81	81	81	81	81	
Syracuse.....	435	33	3,322	396	3,167	52	81	16,105	6,124	81	1,357	304	58	556	439	81	
San Mateo.....	412	42	3,280	217	4,496	216	81	1,233	999	22	581	353	117	215	270	38	
Springfield, Mass.....	582	121	1,944	418	2,990	81	81	81	271	81	81	81	81	81	81	81	
Wichita.....	272	81	2,624	595	1,999	86	81	81	81	317	37	11	147	122	52	27	
Stout City.....	173	16	2,650	220	2,711	12	4,063	12,765	3,497	81	373	84	96	32	199	153	
Duluth.....	598	54	4,525	1,020	4,485	99	21,837	10,680	5,869	81	1,824	1,030	202	472	120	81	

a/ Listed from largest to smallest area population (see appendix table 3).

b/ Includes of live births.

c/ Includes Boy Scouts, Girl Scouts, and Camp Fire Girls.

d/ Area did not report this type of service.

e/ Area reported there was no organized service of this type.

f/ Area not included because data were not available for 1940.

g/ Area reported tuberculosis hospital was closed June 1940.

h/ Area reported there was no hospital limiting its service to tubercular patients.

Note.—This table includes corrections received through March 14, 1942.

social and health service as reported by 42 urban areas, 1941

Health service														Area	
Hospital in-patient						Medical service in-				Group work					
General and special			Tuberculosis			Clinic, other than mental	Patient's home	School health program	Nursing	Public health	Medical-social	Attendance at group activities	Members on national program		Members on local program
Admissions	Patient-days	Free	Admissions	Patient-days	Free	(visits)	(visits)	(enrollment)	(cases)	(field and office)	(patients)	(visits)	(cases)	(cases)	
161,455	2,186,446	926,771	1,107	323,351	296,625	1,322,791	46,109	86,557	5,153	467,680	39,590	2,306,829	324,552	261,255	All areas reporting, to
37,636	693,402	311,512	393	291,152	275,981	1,453,452	44,993	85,695	1,961	267,432	18,283	1,453,452	184,552	145,299	Public hospitals
123,799	1,493,044	615,259	164	32,200	20,644	573,218	1,116	862	3,192	200,248	21,307	2,306,569	324,552	261,255	Private hospitals
26,180	359,952	151,822	239	54,520	51,259	235,177	4	116,854	5,918	1,733	184	29,969	8,799	16,299	Chicago
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	Los Angeles
14,727	205,972	86,138	107	28,753	25,542	96,983	8,336	1,094	704	56,315	1,821	143,425	23,674	9,246	Detroit
10,828	166,598	61,391	74	22,515	20,483	46,687	5,767	4	282	1,705	4	11,594	16,950	9,246	Pittsburgh
9,272	131,243	49,405	32	13,085	12,491	50,947	5,856	6,039	407	32,524	4,287	204,944	14,447	16,077	Cleveland
10,228	151,851	66,316	68	24,407	22,185	77,501	4	6,726	330	15,011	2,440	159,978	21,604	10,584	St. Louis
8,437	144,342	71,560	144	40,268	35,867	70,924	1,797	6,850	4	22,901	1,526	56,475	12,919	6,573	Baltimore
5,505	86,360	31,595	31	13,279	12,741	30,155	4	7,284	407	17,789	1,842	16,144	5,263	5,263	Buffalo
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	Boston
6,560	71,977	22,989	50	16,640	14,507	35,214	1,546	8,873	278	33,324	97	40,917	10,403	7,537	Milwaukee
6,328	96,641	34,495	48	15,884	17,648	56,578	583	647	59	21,215	3,855	129,409	10,522	12,155	Washington, D.C.
6,726	96,136	31,728	42	7,746	6,505	34,638	2,447	3,535	4	14,444	4	111,334	5,705	5,705	San Francisco
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	Cincinnati
6,727	107,019	71,955	11	1,526	1,526	74,841	67	945	127	5,614	4	103,194	9,576	10,168	Minneapolis
3,198	35,820	15,157	14	7,478	7,478	43,265	352	3,964	136	8,755	708	5,770	3,944	3,944	New Orleans
4,537	57,585	25,181	19	6,271	6,271	23,475	1,111	1,290	60	9,360	238	77,253	4,124	4,124	Atlanta
4,717	61,491	36,896	15	7,868	6,660	17,913	2,051	2,135	108	11,462	4	87,545	6,474	5,931	Kansas City, Mo.
2,778	27,263	13,120	30	3,193	2,597	18,456	4	1,150	1	5,729	1,163	107,094	4,501	5,284	Indianapolis
1,726	14,438	10,182	18	3,135	3,135	28,605	1,293	1,182	136	10,558	4	5,743	5,743	5,743	Newark
3,119	40,576	14,734	30	5,827	5,827	18,819	1,365	614	4	8,755	4	110,122	6,176	2,558	Dallas
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	St. Louis
2,329	24,413	4,481	18	5,193	4,880	16,464	895	1,062	43	12,805	4	52,826	6,460	2,218	Columbia
3,511	56,126	20,271	4	2,654	2,719	14,655	1,197	594	222	7,182	2,932	47,513	4,509	10,871	Seoulville
2,164	26,448	7,668	13	3,105	3,105	4	4	2,070	70	7,227	4	105,194	7,618	4,906	Akron
1,363	23,871	15,851	17	6,103	5,068	15,112	4	1,747	296	8,441	321	54,177	4,348	3,422	Denver
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	St. Paul
1,531	20,887	5,462	11	1,942	1,904	5,443	4	3,167	132	5,503	343	15,276	6,294	2,457	Durham
1,468	15,593	1,344	15	4,293	3,135	1,100	4	257	4	5,502	250	50,882	6,114	11,318	Richmond
2,097	26,676	7,703	7	1,531	1,531	11,023	4	4	221	4	266	35,108	3,815	1,951	Providence
1,198	14,313	7,355	4	1,531	1,531	6,854	4	4	39	4	525	4	4,445	3,793	Hartford
2,292	26,665	4,191	23	7,005	7,763	10,376	1,261	2,371	174	7,416	529	61,390	6,123	4,078	Oakland
1,979	23,058	5,317	15	1,705	1,951	6,460	4	2,320	124	5,512	173	57,917	4,036	1,932	Grand Rapids
1,719	11,715	1,150	2	732	732	6,355	218	1,241	11	1,286	173	22,213	7,465	1,853	Canton
1,325	14,697	3,191	26	7,824	7,267	2,586	4	4	38	1,358	80	13,222	3,143	2,441	New Haven
															Wilkes-Barre
															Syracuse
															Des Moines
															Springfield, Mass.
															Wichita
															St. Louis
															Duluth

Appendix table 2.—Percentage change in average monthly figures for selected types of social

Area ^a	Family welfare and relief										Child-welfare service										
	Private agency cases	Cases receiving public assistance										Children under protective and foster care									
		Transient and traveler cases	Public general relief	Special types of assistance			Days' care to adults	Institutional care		Legal-aid cases opened	In parents' homes					Children on day-nursery care	Women under case is maternity home				
				Aid to dependent children	Old-age assistance	Aid to the blind		Mails	Lodgings		Shelter	Total	In parents' homes	In relative's home	In foster homes			In institutions			
All areas reporting, total.	-0.7	-0.1	-34.0	+14.8	+9.5	+1.8	-3.4	-24.6	-20.1	-5.7	-0.3	+1.8	+2.2	-0.3	+2.9	+5.8	+0.2	+3.6	+5.0	+2.5	0
Public agencies.....	-23.0	-34.0	+14.8	+9.5	+1.8	-6.3	-39.2	+37.5	+17.5	+2.9	+5.8	-0.2	+3.6	+5.0	+2.5	+5.8	+0.2	+3.6	+5.0	+2.5	0
Private agencies.....	-0.7	-0.1	-34.0	+14.8	+9.5	+1.8	-3.4	-24.6	-20.1	-5.7	-0.3	+1.8	+2.2	-0.3	+2.9	+5.8	+0.2	+3.6	+5.0	+2.5	0
Chicago.....	+7.6	-16.3	-25.4	+44.9	+6.9	+4.8	+1.3	-37.6	-33.5	+5.8	+3.2	-12.1	+6.1	+0.1	+3.2	+5.6	+0.2	+3.6	+5.0	+2.0	+2.0
Los Angeles.....	+12.2	-16.3	-25.4	+44.9	+6.9	+4.8	+1.3	-37.6	-33.5	+5.8	+3.2	-12.1	+6.1	+0.1	+3.2	+5.6	+0.2	+3.6	+5.0	+2.0	+2.0
Detroit.....	+7.7	-16.3	-25.4	+44.9	+6.9	+4.8	+1.3	-37.6	-33.5	+5.8	+3.2	-12.1	+6.1	+0.1	+3.2	+5.6	+0.2	+3.6	+5.0	+2.0	+2.0
Pittsburgh.....	+5.0	-2.9	-36.3	+57.7	+11.9	+8.2	0	-10.5	-6.1	-0.8	-1.1	+6.2	+1.6	-7.2	-5.3	+14.7	+9.6	+1.7	+1.7	+1.7	+1.7
Cleveland.....	+14.0	-25.6	-35.5	+52.1	+6.9	+4.8	0	-12.6	-16.6	+6.5	-7.6	-14.0	-13.4	-3.7	+5.8	+2.8	+2.8	+2.8	+2.8	+2.8	+2.8
St. Louis.....	-0.3	0	-19.5	+35.0	+13.8	+14.2	0	-18.0	-19.8	0	-1.2	-0.2	-5.7	+1.1	+4.7	+1.6	+1.6	+1.6	+1.6	+1.6	+1.6
Baltimore.....	-15.0	+37.4	-17.2	+18.6	+4.7	+4.0	-5.9	+32.7	+15.5	+13.6	-3.9	-7.3	+7.4	+0.3	+0.1	+7.8	0	+7.8	0	+7.8	0
Buffalo.....	-9.1	+41.1	+0.8	+6.0	-2.1	-3.1	-36.0	-25.1	-7.4	-2.3	-10.9	-12.1	-1.3	+10.8	+24.6	+4.7	+4.7	+4.7	+4.7	+4.7	+4.7
Boston.....	-12.1	-10.1	-27.3	+7.5	+4.4	-2.8	0	-14.1	-7.2	-9.2	0	-6.2	+1.8	+0.8	+4.6	+3.5	0	+4.6	+3.5	0	+4.6
Milwaukee.....	-7.1	-12.9	-42.4	+0.8	+7.8	+1.1	-0.5	0	-9.1	-6.7	-2.9	-17.2	+5.8	+4.6	+3.5	0	+4.6	+3.5	0	+4.6	+3.5
Washington, D. C.....	-4.8	+22.1	+4.5	+4.5	+4.5	+4.5	0	-1.0	-0.2	-16.4	-1.5	-1.9	+0.9	+0.9	+0.9	+0.9	+0.9	+0.9	+0.9	+0.9	+0.9
San Francisco.....	-12.4	-25.2	-46.5	+5.3	+6.2	+3.2	-0.5	-4.4	-2.5	-17.4	-3.5	-7.9	+9.7	-0.2	-5.9	+6.5	+6.5	+6.5	+6.5	+6.5	+6.5
Cincinnati.....	-11.0	+20.5	-27.5	+10.4	+15.9	+2.0	0	-32.4	-28.5	-6.9	-0.5	+1.1	+6.9	+1.7	-2.5	+15.6	+6.4	+6.4	+6.4	+6.4	+6.4
Houston.....	-18.9	-6.7	-3.0	0	+20.2	0	+2.7	-16.3	+37.2	0	+1.2	-6.6	+16.2	+15.3	-9.6	-13.2	0	-13.2	0	-13.2	0
Minneapolis.....	+2.5	-17.4	-25.6	+1.0	-1.0	+7.0	-0.8	0	-1.6	-0.8	0	-1.6	-0.8	-1.6	-0.8	-1.6	-0.8	-1.6	-0.8	-1.6	-0.8
New Orleans.....	+16.9	-15.1	-4.2	+17.2	+15.7	-1.4	-13.2	-16.7	0	+4.0	+9.8	+0.3	+2.2	+4.6	+2.2	+4.6	+2.2	+4.6	+2.2	+4.6	+2.2
Atlanta.....	-2.9	-3.0	-12.5	+25.2	+25.3	+25.8	0	-7.2	-85.5	-0.8	+4.1	+2.0	0	+13.1	-5.1	+0.8	0	+0.8	0	+0.8	0
Kansas City, Mo.....	-5.9	+19.0	-6.8	+31.2	+15.4	-8.0	-6.1	-17.2	-17.1	+35.1	+28.5	+25.2	0	+16.5	-8.4	+7.3	0	+7.3	0	+7.3	0
Indianapolis.....	-9.1	+10.0	-46.4	+0.8	+2.7	+3.0	-12.2	-13.9	-9.7	0	+2.2	+10.1	+6.1	+0.4	+6.8	+6.2	0	+6.2	0	+6.2	0
Birmingham.....	+34.0	+21.6	-7.7	+3.5	+4.5	+6.1	-2.2	+15.8	+31.5	0	+4.8	-30.9	+26.3	+0.6	+4.4	+6.7	0	+6.7	0	+6.7	0
Beverly.....	+11.4	+4.8	-34.5	0	0	0	0	-14.8	-34.8	0	0	0	0	0	0	0	0	0	0	0	0
Dallas.....	+30.1	+9.6	-7.6	+4.4	+29.5	0	+16.6	-21.4	+10.7	-9.6	0	+4.5	+1.0	0	+26.9	+0.2	+3.8	0	+3.8	0	+3.8
Columbus.....	+16.3	+4.1	-28.0	+11.6	+9.4	+2.0	-3.4	-10.6	-9.0	0	-3.0	-3.6	-3.9	-3.9	-3.9	-3.9	-3.9	-3.9	-3.9	-3.9	-3.9
Louisville.....	-5.2	+62.5	+0.9	+30.0	+16.2	0	0	-7.6	+29.6	-15.8	-3.7	+0.5	+0.5	+0.5	+0.5	+0.5	+0.5	+0.5	+0.5	+0.5	+0.5
Albany.....	-6.4	0	+46.9	+22.1	+13.2	+8.5	-2.4	-24.9	-22.4	0	+2.0	+4.9	-16.5	+11.2	+10.2	0	0	0	0	0	0
Denver.....	+14.4	-0.9	+20.9	+6.7	+2.7	+11.1	0	-12.1	+11.1	0	+1.8	+4.4	+9.6	-2.2	+0.5	+6.7	-1.3	+6.7	-1.3	+6.7	-1.3
St. Paul.....	-2.7	-23.6	-33.8	+6.8	+0.5	+9.5	0	-39.8	-73.3	0	0	-2.4	-15.9	+5.7	+1.5	+11.6	-1.4	+11.6	-1.4	+11.6	-1.4
Dayton.....	-22.4	0	+51.0	+15.9	+11.1	-2.1	-12.2	-13.4	+19.4	0	+1.1	+13.9	+2.8	+2.4	+2.4	+2.4	+2.4	+2.4	+2.4	+2.4	+2.4
Richmond.....	-5.3	-1.2	-13.1	+67.7	+16.8	+10.8	+6.0	-1.8	-2.9	0	+0.5	+2.0	0	+4.2	-12.5	+10.0	-12.5	+10.0	-12.5	+10.0	-12.5
Providence.....	-11.9	+61.0	+46.4	+3.5	+3.9	0	-1.2	-34.4	-36.9	-5.3	+11.1	+21.7	+16.8	-2.3	+11.0	+6.0	0	+6.0	0	+6.0	0
San Antonio.....	-7.4	+28.6	+41.5	+6.2	+0.5	0	0	-1.8	-1.8	0	-2.2	0	-1.6	-6.0	+16.3	0	-1.6	0	-1.6	0	-1.6
Omaha.....	-13.5	0	-25.4	+9.9	+2.6	+6.1	+2.2	-6.6	-0.5	0	+1.5	+4.1	0	+5.2	+0.6	+2.6	0	+2.6	0	+2.6	0
Grand Rapids.....	+25.3	0	+25.4	+12.1	+9.0	+31.9	0	-21.0	+16.8	-1.8	-1.3	+13.6	+1.8	-1.2	+1.2	+1.2	+1.2	+1.2	+1.2	+1.2	+1.2
Canton.....	-6.3	-10.0	-46.3	+10.2	+6.5	-3.1	-7.7	+22.0	-0.1	-1.2	+0.9	+1.8	+3.7	+4.5	0	+4.5	0	+4.5	0	+4.5	0
New Haven.....	-6.4	0	-35.0	-12.4	+1.5	+5.6	0	-29.6	-29.7	-1.3	+4.3	+14.0	0	+1.3	+9.6	+16.7	0	+16.7	0	+16.7	0
Wilkes-Barre.....	-5.7	+15.3	+35.0	+91.1	+10.4	+13.7	0	-4.8	-7.6	0	0	0	0	0	0	0	0	0	0	0	0
Syracuse.....	-7.6	0	-27.3	+9.6	+4.2	-1.9	0	-13.0	-29.8	0	-2.2	+7.6	-17.1	+4.6	-3.3	0	0	0	0	0	0
Des Moines.....	+1.2	-17.6	-30.2	-11.4	+3.0	0	0	-29.9	-26.7	0	+1.9	+7.6	+10.3	-2.9	0	0	0	0	0	0	0
Springfield, Mass.....	-2.2	-10.4	-43.8	+4.3	+5.9	0	0	-1.0	-1.0	-2.3	0	0	0	0	0	0	0	0	0	0	0
Wichita.....	+18.1	0	-25.7	+10.0	+5.9	-1.6	0	-1.0	-1.0	0	+10.1	0	0	0	0	0	0	0	0	0	0
Stout City.....	-13.9	0	-16.0	-4.5	+6.6	+1.4	+6.8	-23.8	-25.2	0	+26.4	0	-1.1	0	0	0	0	0	0	0	0
Duluth.....	+5.3	-20.0	-29.1	+0.8	-3.9	-1.0	-2.3	-10.8	-11.2	0	+5.4	+5.3	+14.8	+8.3	-14.9	0	0	0	0	0	0

- ^a Listed from largest to smallest area population (see appendix table 1).
- ^b Exclusive of live births.
- ^c Includes Boy Scouts, Girl Scouts, and Camp Fire Girls.
- ^d Area did not report this type of service.
- ^e Less than 0.05 percent.
- ^f Not computed because there was less than 50.
- ^g Area reported there was no organized service of this type prior to October 1941.
- ^h Area reported there was no organized service of this type.
- ⁱ Area reported there was no organized service of this type prior to February 1941.
- ^j Area not included because data were not available for 1940.
- ^k Area reported tuberculosis hospital closed June 1940.
- ^l Area reported there was no hospital limiting its service to tubercular patients.

Note.—This table includes corrections received through March 14, 1942.

and health service as reported by 42 urban areas for 1941 as compared with figures for 1940

Health service														Group work		Social service exchange clearance	Area and
Hospital in-patient							Medical service in-							Attendance at group activities	Members on health program registers		
General and special		Tuberculosis		Chest, other than tuberculosis		Patient's home visits	School health program (consultations)	Mental hygiene clinic (cases)	Public health nursing (field and office) visits	Medical-social service (patients)	Attendance at group activities		Members on health program registers				
Admissions	Patient-days	Admissions	Patient-days	Admissions	Patient-days	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	
Total	Free	Total	Free	Total	Free	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	
+6.6	+4.3	+5.8	+6.1	+2.5	+1.8	-6.3	-12.1	-2.3	-5.0	+0.5	-3.1	-1.2	+5.2	+2.1	All areas reporting, total		
-1.4	-2.7	-4.5	+9.1	+3.5	+2.9	-7.8	-11.5	-2.5	-5.8	-0.4	-3.5	-0.5	+5.2	Public auspices			
+9.2	+7.9	-8.5	+2.5	-5.9	-10.7	-4.9	-32.5	+15.1	-4.7	-0.6	-2.8	-1.2	+5.2	Private auspices			
+6.1	+4.6	-7.0	+5.3	-2.3	-3.1	-8.9	0	0	0	0	0	0	0	Chicago			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	Los Angeles			
+14.2	+7.1	+5.7	+15.6	+6.7	+4.4	-10.0	-26.3	-1.6	-5.2	-5.1	-6.0	0	+4.9	Detroit			
+6.9	+6.0	+5.2	+12.1	+16.4	+10.5	-8.0	-16.0	0	-9.9	-3.1	-8.5	-3.7	+5.0	Pittsburgh			
+7.5	+5.6	-4.3	0	-0.2	-1.7	-5.2	+6.5	+4.5	+1.0	-1.5	+22.4	+14.9	+7.5	Cleveland			
+5.7	+5.0	0	+17.2	+12.0	+13.2	-7.4	0	+3.7	+18.3	+5.1	-4.8	-7.5	+17.7	St. Louis			
+3.9	+0.2	-12.0	+10.8	+3.3	+1.8	-11.7	+17.6	-0.2	0	-1.7	-15.3	-7.5	+4.5	Baltimore			
+8.2	+2.6	-18.0	0	+0.5	+0.4	-17.4	0	-8.5	-25.3	+1.9	-3.2	0	+4.4	Buffalo			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	Boston			
+5.2	+4.7	-10.6	-3.8	+8.8	+3.2	-16.0	-36.4	+8.9	+5.7	-5.6	-11.8	-3.0	+3.8	Milwaukee			
+5.1	+10.0	+13.2	0	+0.7	+4.6	+0.9	+0.7	0	-10.1	+6.2	-6.3	+0.7	+0.2	Washington, D.C.			
+6.8	+0.2	+3.7	0	+70.3	+115.8	-8.6	-21.8	-8.6	0	-3.4	-13.4	-11.0	+6.2	San Francisco			
0	0	0	0	0	0	-1.9	-13.1	+4.5	+18.0	-7.8	0	+3.4	+11.0	Cincinnati			
0	0	0	0	0	0	-10.0	-28.0	-28.8	+11.5	+10.0	-31.6	-8.9	+0.9	Houston			
-2.8	-1.4	-5.3	0	-3.5	+1.8	+10.1	-60.4	-70.9	-17.0	-1.6	0	-2.8	0	Minneapolis			
+5.1	+4.0	-2.0	0	+0.5	+2.5	+18.2	-27.0	0	-15.2	+13.3	0	0	+8.3	New Orleans			
+4.2	+3.9	-1.0	0	-11.1	-11.1	+3.4	+22.5	-3.9	0	+4.6	-10.9	-1.4	0	Atlanta			
+7.3	+6.3	+5.9	0	+0.8	+3.5	+5.8	+10.7	-5.8	+6.9	+1.2	0	+0.1	+0.1	Kansas City, Mo.			
+17.3	+10.6	-12.5	0	+17.2	+28.9	+6.7	0	+42.2	0	+0.8	+40.7	+10.8	+2.4	Indianapolis			
+9.6	+1.3	-5.0	0	0	0	0	0	+15.4	0	-8.6	0	0	+7.5	Birmingham			
+4.7	+5.7	-7.9	0	+4.3	+5.2	+8.4	-8.2	+11.0	0	+0.8	0	+6.5	+21.0	Peoria			
0	0	0	0	0	0	+6.7	-19.2	0	-12.1	+10.7	-17.0	-17.1	+3.0	Salina			
+6.7	+6.7	-10.0	0	-10.1	-10.1	-14.9	+28.0	+28.6	0	-18.8	0	+10.6	+5.0	Columbus			
+6.2	+6.0	-4.9	0	0	0	-4.8	-4.0	-8.3	+5.4	+1.2	-18.8	-7.4	+0.8	Louisville			
+11.0	+9.5	-9.4	0	-21.9	-21.9	0	0	+12.4	+13.6	-2.2	+4.6	-0.8	-2.5	Akron			
+12.3	+2.1	-7.2	0	+3.4	+4.3	+7.9	0	+1.9	-2.8	-1.0	0	+3.7	+6.2	Denver			
0	0	0	0	0	0	-5.7	-1.6	0	-1.6	+3.0	0	+6.6	-4.9	St. Paul			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dayton			
+6.9	+8.7	-2.7	0	+12.7	+14.6	-18.5	0	0	0	0	0	0	0	Richmond			
+18.8	+20.9	-24.0	0	+1.2	-3.1	-10.4	0	+0.2	0	+7.6	0	0	0	Providence			
+4.6	+1.7	-18.0	0	0	0	-11.3	0	+12.6	0	0	0	0	0	Hartford			
+1.9	+0.2	-8.5	0	-6.1	-8.1	-4.3	0	0	0	0	0	0	0	Omaha			
-1.1	-1.0	-13.5	0	+2.1	+1.3	-11.8	-18.9	+36.8	-7.4	+0.2	-25.9	+12.7	+1.4	Grand Rapids			
-0.1	+0.4	-7.7	0	-10.3	-9.1	-8.0	0	-8.1	0	-6.8	0	+10.0	+3.8	Canton			
-9.5	+7.4	0	0	0	0	-12.4	0	+5.5	0	+0.2	-10.8	0	0	New Haven			
0	0	0	0	0	0	-12.5	0	+9.4	0	-7.7	0	-12.5	0	Worcester			
+7.7	+3.9	-12.5	0	0	0	-10.9	+3.6	0	0	-16.9	0	+7.0	-0.8	Springfield, Mass.			
+1.9	-0.3	-19.3	0	+17.8	-17.8	-12.6	0	0	0	0	0	0	0	Wichita			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	St. Louis			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	Duluth			

Appendix table 3.--Description of 42 urban areas

Principal city	1940 population	Registration area includes--
Total, 42 areas.	26,848,154	.....
Chicago.....	4,063,342	Cook County
Los Angeles.....	2,785,643	Los Angeles County
Detroit.....	2,015,623	Wayne County
Pittsburgh.....	1,411,539	Allegheny County
Cleveland.....	1,217,250	Cuyahoga County
St. Louis.....	1,090,278	City and St. Louis County
Baltimore.....	859,100	City
Buffalo.....	798,377	Erie County
Boston.....	770,816	City
Milwaukee.....	766,885	Milwaukee County
Washington, D. C.	663,091	City
San Francisco.....	634,536	City (Territory is coterminous with County)
Cincinnati.....	621,987	Hamilton County
Houston.....	528,961	Harris County
Minneapolis.....	498,225	City and village of Edina; but in fields R-2 and R-3 the territory includes Hennepin County with a population of 568,899
New Orleans.....	494,537	City (Territory is coterminous with Orleans Parish)
Atlanta.....	479,828	DeKalb and Fulton counties
Kansas City, Mo...	477,828	Jackson County
Indianapolis.....	460,926	Marion County
Birmingham.....	459,930	Jefferson County
Newark.....	429,760	City
Dallas.....	398,564	Dallas County
Columbus.....	388,712	Franklin County
Louisville.....	385,392	Jefferson County
Akron.....	339,405	Summit County
Denver.....	322,412	City (Territory is coterminous with County)
St. Paul.....	309,935	Ramsey County
Dayton.....	295,480	Montgomery County
Richmond.....	266,185	City and Chesterfield and Henrico counties
Providence.....	253,504	City
Hartford.....	248,128	City, and towns of Bloomfield, East Hartford, Newington, West Hartford, Wethersfield, and Windsor
Omaha.....	247,562	Douglas County
Grand Rapids.....	246,338	Kent County
Canton.....	234,887	Stark County
New Haven.....	223,093	City, and towns of East Haven, Hamden, and West Haven
Wilkes-Barre.....	221,687	City, and townships of Dallas, Hanover, Kingston, Plains, and Wilkes-Barre, and boroughs of Ashley, Courtdale, Dallas, Edwardsville, Forty Fort, Kingston, Larksville, Luzerne, Plymouth, Pringle, Sugar Notch, Swoyersville, and Warrior Run
Syracuse.....	218,688	City, and villages of East Syracuse and Solway; but in fields R-2 and R-3 the territory includes Onondaga County with a population of 295,108
Des Moines.....	195,835	Polk County
Springfield, Mass.	175,882	City, and towns of East Longmeadow, Longmeadow, and West Springfield
Wichita.....	143,311	Sedgewick County
Sioux City.....	103,627	Woodbury County
Duluth.....	101,065	City; but in fields R-1-B, R-2, R-3, C-1 and C-2, and C-4 the territory includes St. Louis County with a population of 206,917

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